Core Concepts in Positive Psychology & Logotherapy: Principles and Practice

Dagmar Devorah Fabry, Ph.D. & Paul Perry
Statue of Responsibility
It starts with you!

THE WHOLE WORLD IS INVITED
Core Concepts in Positive Psychology & Logotherapy:

Principles and Practice

by

Dagmar Devorah Fabry, Ph.D. &
Paul Perry
Dedication

The first author would like to dedicate this book to Rabbi M. M. Schneerson of Blessed Memory. He taught that all people have the capacity, and indeed duty, to rise above their circumstances and find the highest degree of fulfilment for themselves and others. Also to her father, Prof Alfons Fabry, who practiced the Goethe maxim “If we take man as he is we make him worse, but if we take him as he should be, we make him capable of becoming what he can be” (Frankl, 2010).
Acknowledgements

The authors would like to thank Prof Milne and Dr Zeig for comments on earlier drafts, as well as H. L. Bootsman for her valuable ideas. They are also indebted to the trainees at the Newcastle Doctorate in Clinical Psychology for their interest and enthusiasm in learning about Positive Psychology and Logotherapy, which has sustained the authors’ motivation to bring this work to completion.

Between stimulus and response, there is a space.
In that space lies our freedom and our power to choose our response.
In our response lies our growth and our happiness.

Anonymous, cited in Covey, 2004, viii

This three-liner captures Positive Psychology’s and Logotherapy’s essence. It conveys that ‘we can become the product of our decisions, not our conditions’ (Covey, 2004, ix)
Introduction

This compendium started as a glossary for trainees at the Newcastle Doctorate in Clinical Psychology who attended an optional Logotherapy reading and practice seminar. When the first author came across Pliskin (1993), she was inspired to develop this compendium into a similar resource of techniques and suggestions. The authors’ interest in Positive Psychology led to an inclusion of this new movement, which is built on humanistic psychology in general and overlaps – at least in part - with Frankl’s work (Peterson & Seligman, 2004). To balance off the Diagnostic and Statistical Manual’s (DSM IV-TR) problem focus, Peterson & Seligman (2004) developed ‘Character Strengths and Virtues – A Handbook and Classification’ comprising 24 character strengths clustered under six headings called ‘virtues’.

Thus this compendium has become a collection of Positive Psychology and Logotherapy’s terms, techniques and procedures. In addition, some problem areas and diagnoses have been included, to show how the logotherapist and positive psychologist might treat this difficulty.

Each entry is organised in a structured fashion encompassing:

Description: A brief account of what this term means.

Background: A fuller elaboration of the term and where Positive Psychology and/or Logotherapy may play a part in improving the situation for the client. Where appropriate, reference is made to the Diagnostic and Statistical Manual IV (DSM IV-TR) (APA, 2000) as well as to its counterpart, Character Strengths and Virtues (CSV), the Handbook and Classification by Peterson & Seligman (2004).

Evidence-Base: Findings such as Randomised Controlled Trials (RCTs) ascertaining the technique’s effectiveness. In case of a problem area, evidence-based guidelines have been included, which were produced for the United States by the Society for Clinical Psychology (SCP) and/or Division 12 of the American Psychological Association (APsA, United States) as well as by The Society of Clinical Child and Adolescent Psychology (SCCAP), and for the United Kingdom by the National Institute for Clinical Excellence (NICE), respectively.

Example: To illustrate how this techniques works or how to treat this problem area in practice, the authors present short case vignettes from the Positive Psychology/Logotherapy literature or from their own practice.

Exercise: This experiential part of each entry is meant to help the reader try out some of the techniques and ideas as well as personally experience the effect/s of the approach described above. It thus helps integrate the personal and the professional self in a fashion which is true to the aims of Personal Professional Development (PPD; see Gillmer & Marckus, 2003; Sheikh, Milne & MacGregor, 2007). The value of self-care (Ungar, Mackey, Guest & Bernard, 2000), strength-based development (Hodges & Clifton, 2004) and ‘self- practice/self- reflection’ in Cognitive Behaviour Therapy (CBT; see Bennett-Levy, 2006) cannot be underestimated. To this end, we recommend that readers keep a Reflective Journal where they jot down their own
thoughts and examples and where they collect their work on their experiential journey.

These five headings hopefully contain all one would wish to gain from such a compendium. This book is meant to serve the interested layperson as well as students, trainees and health care practitioners of various approaches and professions. As Positive Psychology and Logotherapy lend themselves to therapy integration (see Frankl, 1985; Boniwell, 2005; Fabry, 2005; Fabry, Sheikh & Selman, 2007), practitioners in the helping professions may pick and choose what they deem helpful in their attempt to alleviate suffering and enhance growth, both their clients’ and their own (see PPD above).

N.B. Terms in **bold** and marked with an asterisk have a separate entry.
So what are Logotherapy and Positive Psychology?

a) **Logotherapy**

The term ‘Logotherapy’ is derived from ‘logos’ (Greek: Word; Meaning). Thus, Logotherapy is a meaning-centred form of psychotherapy with links to existential and humanistic psychotherapy. Even before WWII, the psychiatrist Professor Viktor E. Frankl created this form of therapy in his attempt to support his patients who were suffering from major depression. Instead of focusing on the psyche, this approach centres around purpose and meaning. This was due to Frankl’s own search for meaning as a young person (Mendez, 2004). Logotherapy contains three main tenets, also called pillars, which describe its value base and stance (see Mendez, 2004). They are:

1. ‘Meaning of Life’, i.e. the philosophical assumption that life is intrinsically meaningful,
2. ‘Freedom of Will’, which is the anthropological tenet that human beings have a choice in how to respond to any given circumstances they may find themselves in, and
3. ‘Will to Meaning’, which enables human beings to endure suffering as long as it is purposeful. This “is the clinician’s strongest ally against apathy, and a healing resource…” in psychotherapy (see Mendez, 2004, p. 47).

Benware (2003) found that CBT and Logotherapy have a compatible, and in most cases identical, epistemology and value base. In particular, “Freedom of Will” is part of the CBT assumptions. Tenet 3 is part of Formulation* in Clinical Psychology which fulfils the function of making sense of the situation the clients find themselves in, in light of psychological, evidence-based theory.

Batthyany & Guttmann (2005) collated an extensive bibliography of Logotherapy’s evidence-base. In addition, the extensive evidence base for the logotherapeutic technique of Paradoxical Intention* has been examined by a number of authors (e.g. Michelson et al, 1990; Espie et al, 1989; Ascher & Turner, 1980; for reviews see Morin et al, 1999; Michelson & Ascher, 1984; Fabry, 2010).

An example of Logotherapy’s tool box is Life Review & Preview by Dr. Lukas, encompassing nine stages of life. It starts with describing parents, early childhood, and school years, carrying on with early adulthood, present, near and distant future, then also including dying, and traces one wants to leave on earth. The client should reflect on these stages by focusing on facts as well as feelings, thoughts, position towards it, response, acceptance and any further action (see Mendez, 2004). This exercise can be used to enhance awareness of one’s Values*. 

b) **Positive Psychology**

Positive Psychology was founded by Professor Martin Seligman (2005) as a movement which was to balance the rather problem focused stance of Psychology up to then. Seligman started this movement following a personally enlightening experience with his young daughter, who had suggested that he should and could cheer up. This made him acutely aware of his own personal situation (and need to change towards being ‘happier’), as well as about psychology and its main focus on alleviating distress rather than enhancing well-being (Seligman, 2005).

Positive Psychology’s aims are to:

a) deal with strengths as well as difficulties,

b) nurture the best as well as repair the worst,

c) support people in living fulfilling lives & enhance talent as well as heal illness (Seligman, 2004).

Positive Psychology holds that there are three ways of living a “happy life”:

a) the pleasant life with positive emotion, yet its effect is quickly gone.

b) the good life, which means engaging in life, including ‘flow’ (Csikszentmihalyi, 2005), and using your strengths.

c) the meaningful life, life with a purpose, engaging with something that’s higher than yourself (Seligman, 2004).

This is an evidence-based branch of psychology with impressive and growing research to prove its effectiveness (Snyder & Lopez, 2005; Linley & Joseph, 2004; Peterson & Seligman, 2004).
c) **Logotherapy as one of Positive Psychology’s Forerunners?**

At a time, when Psychology was largely concerned with unconscious drives, Frankl stood up for the importance of a future-oriented focus, an aim and purpose in life to channel one’s energies and ambitions. This, he suggested, was what helped people overcome their weaknesses as well as supporting them in coming to terms with strokes of fate. 80 years later, Seligman discovered, that Psychology’s problem focus needed to be balanced by a strong engagement with human strength and talent.

Thus, not surprisingly, Lewis (2011) finds various areas of overlap between Logotherapy and Positive Psychology, such as “an acceptance of human spirituality, an emphasis on human strengths and values, an appreciation of beauty, gratitude and humour, and an interest in a fulfilling and meaningful life” (Lewis, 2011, p. 24). He cites Klingberg (2009) who describes how Logotherapy can be seen as a forerunner of Positive Psychology. These humanistic aspects of Logotherapy and Positive Psychology bear strong semblance of each other.

Yet there are differences and even apparent contradictions, such as Positive Psychology’s goal to pursue happiness which seems to contradict Logotherapy’s explicit credo that happiness cannot be pursued directly but must develop as a by-product of one’s meaningful encounter with the world, be it in creating something, encountering someone or changing oneself (Frankl, 1985).

In addition, Logotherapy holds in its existential tradition that an important part of life is suffering and how to bear it. This part seems to sit less comfortably with Positive Psychology’s happiness focus.

To put it more clearly, there might be a notion of Positive Psychology being more goal-oriented by trying to directly achieve what Logotherapy sees as a by-product. The readers, being aware of the commonalities as well as the tension between these two schools in Psychology and Psychotherapy, may choose for themselves whether to and how to reconcile these two stances. The authors hold, that there are enough commonalities to allow an integrated approach utilising both in one’s attempt to support those who are struggling.
Addiction:
Description: Also called substance misuse, this problem area encompassing drug and alcohol misuse has received wide attention due to its strong impact on general functioning.

Background: The Diagnostic and Statistical Manual of Mental Disorders IV-TR (DSM IV-TR) identifies Addiction dependence as being preoccupied with the substance even when not using it, tending to use more than expected as well as more and more as time goes on, having withdrawal symptoms when stopping using the substance and using it to prevent those symptoms, trying to reduce or discontinue using the substance, being under the influence of the substance at inappropriate times such as at work/school/social events, withdrawing from other activities in favour of substance use, carrying on with substance use in light of disadvantage and suffering from negative consequences (see alcoholanddrugabuse.com).

Addiction is part of the Neurotic Triad (Frankl, 1985) encompassing Aggression, Depression*, and Addiction. They can be seen as ‘explosion’, ‘implosion’ and ‘numbing out through substance abuse or addictive behaviour’ (Sjölie, 2008, p. 80).

Koob (1999) found “Sucht” (Addiction) comes from “Sehnsucht” (desire). Thus, ‘addiction’ comes from seeking to ‘add’ something to one’s life’, be it excitement, tranquillity, happiness, Flow*, freedom from disturbance etc. Treatment is geared towards helping clients find meaning (e.g. Addad & Himi, 2008). This is achieved by developing real emotions through goals, relationships, and new attitudes instead of chemicals. Taking responsibility for one’s and other’s well-being replaces the quick fix of chemicals.

Evidence-Based: SCP is preparing recommendations.

NICE Guidelines recommend for Addiction:

Table 1: Summary of NICE Guidelines (2006) for Drug Misuse

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Contact</td>
<td>Brief interventions should be offered to those people with limited contact to drug services (i.e. needle exchange) consisting of 1-2 sessions lasting 10-45 minutes to explore the ambivalence to drug use, possible treatment and increasing</td>
</tr>
</tbody>
</table>
Contingency management principles should also be in place to increase motivation to promote engagement with services and for the reduction of harm. These could include

- Vouchers/privileges to use methadone at home etc based on a negative drug testing.
- Hepatitis B/C, tuberculosis and HIV testing

Providing support and information to families and carers.

<table>
<thead>
<tr>
<th>Self Help Interventions</th>
<th>Staff should routinely provide self-help information including self-help groups (i.e. Narcotics Anonymous, information on 12 step programmes) for all those using drug services.</th>
</tr>
</thead>
</table>

**Detoxification**

Detoxification should be readily available to those with informed consent. To obtain consent, staff must be trained in the following areas of detoxification and provide information on the following:

- The physical and psychological aspects of withdrawal, including the duration and intensity of symptoms
- The use of non-pharmacological approaches to manage or cope with withdrawal
- The loss of tolerance following detoxification. Therefore making sure a client is aware that there is a heightened potential of overdose and death from drug use, especially alcohol and benzodiazepines.
- The importance of continued support, as well as psychosocial and appropriate pharmacological interventions, to maintain abstinence, treat co-morbid mental health problems and reduce the risk of adverse outcomes (including death).

**Formal Psychological Interventions**

Behavioural couples therapy

Consider behavioural couples therapy for people who are in close contact with a non-drug-misusing partner and who present for treatment of stimulant or opioid misuse, including those who continue to use illicit drugs while receiving opioid maintenance treatment or after completing opioid detoxification. The intervention should:

- focus on the service user’s drug misuse
- consist of at least 12 weekly sessions.

Cognitive behavioural therapy and psychodynamic therapy
Consider evidence-based psychological treatments (in particular CBT) for comorbid depression and anxiety disorders for people who:
- misuse cannabis or stimulants
- have achieved abstinence or are stabilised on opioid maintenance treatment.

Do not routinely offer CBT and psychodynamic therapy focused on the treatment of drug misuse to people who misuse cannabis or stimulants or those receiving opioid maintenance treatment.

Positive Psychology can be used as a supplement to CBT by focusing on and amplifying the **Strengths** of the client and promoting (self-) **Forgiveness**. In a national study by Wuthnow (2000), overcoming **Addiction** was one major outcome of participation in small religious groups, and stronger **Meaning in Life** was detected in recovery in contrast to drug users (Addad & Himi, 2008).

**Example:** According to Frankl (1996), substances or behaviours are used to avoid negative feelings of perceived meaninglessness. In logotherapeutic settings such as the Centro Italiano di Solidarieta, young clients with addictions are supported to care and take responsibility for each other and so become able to develop real friendship and consideration. They experience being important and valued, instead of looking for artificial manipulation of their emotions via drugs (Bootsmann, personal communication, 2009).

**Exercise:** Think of a time when you felt frustrated – or take a frustration you are aware of now. You may have felt/feel like using alcohol, caffeine, nicotine, foods with high sugar/fat content etc. as a way of soothing your feelings. What kind of thoughts could have gotten/get you ‘out of the rut’? Consider normalising aspects such as that many people will think/act this way sometimes, as well as meaning aspects such as this being a test of your inner resources and strengths, focusing on the overall picture rather than details etc. In addition, using Koob’s (1999) idea that ‘addiction comes from trying to add something to one’s life’, think how you could express your craving for a certain substance in a meaningful/spiritual way, e.g. by meditation, a walk, a conversation, music, art, prayer, etc. Please note down your thoughts in your Reflective Journal.

**Adolescence:**

**Description:** Adolescence is a time of transition and search for identity (Erickson, 1968). This transitional period is not always plain sailing and can bring with it conflicting demands from adults and peers which can lead to confusion, anxiety and depression.

**Background:** Frankl suffered from doubts about the meaning of life in his youth (see Mendez, 2004). Blair (2004) suggests in his article on adolescent depression to reduce the **Existential Vacuum** by helping young people find meaning and pursue a purpose. This then becomes their guiding star which helps them achieve attitudinal change, learn necessary skills and solve any problems on the way.

In Blair (2004), this Mental Health Counsellor (MHC) and lecturer suggests the following steps in Logotherapy with adolescents:

1. Establish a therapeutic relationship by non-judgemental listening and careful questions. The therapist may also wish to use self-disclosure to illustrate a point or as an analogy for their
current situation, e.g. coping with physical pain being similar in some way to adolescents dealing with emotional suffering.

2. In this second stage, the focus of the encounter is on understanding the adolescents’ aims, values and identity. The therapist helps the young person to express and value their pain and suffering as an expression of their being. Their dreams and aspirations are explored as well. This is done through Socratic Dialogue*, i.e. asking questions which help the young person express their values, goals, strengths, and capabilities, leading to problem-solving around resources and supports available.

3. Clients are now ready to explore the possible meaning and message of their pain and suffering, listening to what it might like to tell them about possible changes necessary to lead a more fulfilled and balanced life.

4. “Discovering Meaning Within the Depression” is carried on by letter writing to the depression, asking their questions as to why it has come along and documenting how it has made them suffer. They then write a letter back from the depression to the person, explaining its meaning and purpose. They often find they have dormant potential that can be accessed and expressed in a meaningful way.

5. In this final stage, adolescents become active around putting into practice what they have learned so far, e.g. by noticing their need to change, breaking it down into different aspects, and slowly advancing step by step (Blair, 2004).

Evidence-Base: The evidence-base for Socratic Dialogue* is discussed below. Letter writing to the problem and back from the problem to the person has been researched in and around narrative therapy. For a summary, see Pyle, 2006.

Example: A “young mother … was HIV positive … and grieved the loss of years she thought she would have. I asked, “How could the remaining time you have be optimally used?” … she wanted to be the best mother to her children for whatever time she had left… we discussed what it meant to be a “good” mother, what changes she would need to make, and how she could improve her capacity to care for her children… addictions and … difficulty providing adequate care to her children … might result in the loss of her children… Slowly, by allowing the meaning she had discovered to guide her, by taking responsibility for her choices, and by continually making small changes …, she was able to make some progress in her chosen meaning: being the best mother she could to her children”. (Blair, 2004, p. 344f.)

Exercise: To help parents develop Empathy* with their adolescent child/ren and vice versa, use a situation where you are in conflict and change roles for a brief period of time. Role play each other, e.g. mother playing adolescent son who puts off doing his household chores, while her son plays his mother trying to reason with her son to stop putting this off and get on with them (Seligman, 2007).

Reflect on how you can use this exercise with your client/s. Commit your thoughts to your Reflective Journal for future reference.

Altruism:

Description: “Altruism refers to a specific form of motivation for one organism, usually human, benefiting another.” (Batson, Ahmad, Lishner, & Tsang, 2005, p. 485). This is in contrast to altruistic behaviour, which can be displayed due to egoistic motivation as well as an altruistic one. Altruism as a personality factor is a concept found in the Character Strengths and Virtues: Handbook and Classification (CSV; Peterson & Seligman, 2004).
Background: Frankl (1985) described altruistic acts both by himself and others in the concentration camps, subsuming them under the umbrella term of (self-) **Transcendence***. In Positive Psychology, it has been found to be related to **Empathy*** in that feeling for the other makes **Altruism** more likely to occur. This can be trained, as the example below illustrates.

Evidence-Base: Does true **Altruism** exist? Although altruistic acts are sometimes motivated by self-benefit, the evidence suggests that this is not always the case (Batson, Ahmad, Lishner, & Tsang, 2005). Research shows, that the mechanism by which un-selfish giving occurs, is compassion or **Empathy***.

**Example:** A person jumps off a bridge into the water. Another person jumps in to save the first one. When asked why he did this, he replies there was no other choice than try and save the drowning person. Frankl (1996) explains that as this person had accustomed himself to helping those in need, this heroic act had become natural for him. This shows how habitual performance of certain kind deeds can transform a person’s way of reacting in a positive way (and vice versa).

**Exercise:** Give a small amount of charity to 10 poor people over the next 10 days. On the 11th day, let the next poor person you encounter have a larger amount. What has changed since you started this experiment? In which way does this affect your work and personal life? **Reflect!**

**Anxiety:**

**Description:** The person feels unable to feel safe in certain situations and so shows inadequate reactions due to **Anxiety***, which in turn reinforces concerns about these situations and leads to the neurotic vicious cycle (Lukas, 1986a).

**Background:** This excessive **Anxiety*** – contrary to normal fear which belongs to life – can be seen as grounded in a high awareness of vulnerability and destructibility of the person, not only physically, but also in their personality. People who believe they can be totally destroyed, will focus their efforts on avoiding this as long as possible, implementing safety mechanisms like avoidance, magical rituals or clinging to others for protection and reassurance. Furthermore, the constant **Anxiety*** brings the vegetative system into a state of alarm which reinforces the **Anxiety*** (Bootsmann, personal communication, 2009).

**Evidence-Base:** SCP recommends CBT which has strong research support for Generalised **Anxiety*** Disorder as well as Social Phobias. Exposure is recommended for Specific Phobias. NICE guidance suggests:

**Table 2:** Summary of NICE Guidelines (2004) for Anxiety.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Treatment / Management</th>
<th>Monitoring</th>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be alert to comorbidity, which is common (particularly anxiety with depression and anxiety with substance abuse).</td>
<td>CBT should be used. Adhere to empirically grounded treatment protocols. CBT should be in weekly sessions of 1-2 hours and completed within 4</td>
<td>Assess progress according to process within the practice. Determine the nature of the process on a case-by-case basis. Use short, self-complete</td>
<td>If, after reassessment there is no improvement, then further interventions revolve around SSRI administration.</td>
</tr>
</tbody>
</table>
Identify the main problem(s) through discussion with the patient.

Clarify the sequence of the problems to determine the priorities of the comorbidities. Drawing up a timeline to show when different problems developed can help with this.

months of start date. The optimal range is between 16-20 hours total. If offering briefer CBT, it should be about 8-10 hours, should be designed to integrate with structured self-help materials, and should be supplemented with appropriate focused information and tasks.

questionnaires to monitor outcomes wherever possible.

Combining Positive Psychology and Logotherapy with SCA and NICE recommendations means including Strengths* as well as difficulties, e.g. when drawing a timeline (see above). Paradoxical Intention* may be possible in cases of anxiety. It has a growing evidence-base for cases of agoraphobia and public speaking anxiety (For a review, see Fabry, 2010; see also below under Paradoxical Intention*).

Example: Joseph Fabry (who is not a close relation of the first author) describes his case of performance Anxiety*. He employed Paradoxical Intention*, using intention of ‘failure’ to overcome his fear of making a fool of himself when presenting on Logotherapy at a conference with Frankl (Fabry & Lukas, 1995).

Another example is a person at a dinner party, who chokes on his food, gasping for breath which he finds very embarrassing. Following this incident, he develops an Anxiety* of choking, suffocation and having to vomit, especially in the company of other people. Therefore, he avoids going out and eating with others, carries around spasmyolic remedies at all times and finally eats only mashed foods even when at home by himself. With Paradoxical Intention*, the client will be asked to expose himself to dinner parties and provoke as much choking, vomiting and suffocation as possible (Bootsmann, personal communication, 2009). When saying this in a humorous manner, the client may start laughing. Thus, self-distancing through Humour* is achieved, which has a growing evidence base (see example for Humour*).

Exercise: Imagine any embarrassing, Anxiety*-provoking or unpleasant situation you have experienced and did not want to experience again, as a child or adult. Did you try to avoid the situation in the future? Did you develop magical rituals (e.g. counting, taking certain steps, wishful thinking etc.) to protect you? What happened when you were in a similar situation – did you experience any fear or any physiological symptoms? What did you do? Were you able to meet the challenge, saying to yourself that you would act differently than last time, thus making use of the space between stimulus and response called choice (see citation in the introduction above)?
Assessment:
Description: Positive Psychology advocates a Four Front Approach to Assessment* (Wright & Lopez, 2005), placing equal emphasis on assessing a) positive and b) negative aspects of c) the person and d) the environment.

Background: Also called Alternate Diagnosis (Lukas, 1986a), Logotherapy advocates that the therapists ask about Strengths* as well as difficulties right from the start of the therapeutic engagement, i.e. in the Assessment* and diagnostic/Formulation* stage. In the intake interview (as well as in subsequent sessions), the therapist uses alternating questions to explore problem areas as well as questions about functional, enjoyable and fruitful areas of the client’s life (Lukas, 1986a). This is done in order to prevent an increase in the clients’ anxious reflection about their problems (Lukas, 1986a), i.e. Hyperreflection*, similar to rumination. In the example below, only two questions (A and D) deal with the client’s presenting difficulties (Lukas, 1986a).

Authors such as Kuyken, Padesky & Dudley (2009) emphasize: “From the initial assessment therapists look for client strengths…” (Kuyken, Padesky & Dudley, 2009, p. 308),

Evidence-Base: Evidence comes from Assessment of positive and negative aspects of the person and the environment (see Wright & Lopez, 2005 for a summary).

Example: “In ... insomnia, …:

A. Query about frequency of sleep disturbances. Talks about such subjects as day and night rhythms.
B. Query about activities which the client likes to do to which she could turn in sleepless hours (reading, listening to music, solving puzzles, cooking).
C. Discussion of these activities and her experiences with them.
D. Query about connections between emotionally strenuous human encounters and the occurrence of sleep disturbances.
E. General dialogue about the client’s encounters with relatives, friends, acquaintances.
F. Discussion about possible links between some of these persons and the client’s hobbies, inclinations and interests.” (Lukas, 1986a, p. 43).

Exercise: Role play with a friend/colleague an Assessment of one of your referrals using alternate Assessment from an “explorer role” perspective, deciding to “take only photos and leave only footprints.” (Ingram, 2006, p. 28).

De-brief afterwards reflecting on your observations.

Attitudinal Change:
Description: Frankl (1985) teaches that if all else is impossible, you can still change yourself, i.e. the way you think and feel about a certain, unchangeable situation by finding Meaning* and benefit in it. This can be done in any situation through discovery techniques such as Counting Your Blessings*, Expressive Writing*, Socratic Dialogue*.

Background: If creating something or experiencing something or someone to find meaning are impossible, e.g. when facing tragedies such as loss of loved ones or own physical or mental faculties, there is still a choice as to how the person responds to the situation. In Frankl’s experience in concentration camps, he used the time to encourage and support others, thereby enhancing his sense of meaning rather than remaining a passive victim of the situation.

Mendez (2004) describes how the therapist supports the client in developing a changed attitude:

1. Explore the patient’s current situation, and understand the cause of the suffering they experience;
2. Look for roots of the suffering and see where there are realistic limitations;
3. Notice also the strengths and possibilities;
4. Notice the unhealthy attitude which increases the suffering and try to change... [it];
5. Bring the findings to the awareness of the patient and discuss them openly;
6. Help to affirm the belief in life’s meaningfulness and one’s unlimited personal worth;”

Evidence-Base: **Attitudinal Change** can be achieved through various means such as **Counting Your Blessings**, **Expressive Writing**, **Socratic Dialogue**. The evidence-base for these techniques is discussed under their respective entries.

**Example:** A bereaved doctor came to Frankl (1985), distraught and hopeless. Frankl helped him change his attitude to his predicament from that of a victim to that of a hero: Through his suffering he was sparing his wife suffering (of being the one to survive the spouse). With this new attitude, the pain was transformed from a meaningless burden into a meaningful sacrifice, i.e. as an expression of his love for his wife.

**Exercise:** In the workplace, **Attitudinal Change** may help you overcome despair regarding work conditions or other troublesome aspects. Remembering the situation that made you unhappy, explore whether you felt like a victim or whether you could see some responsibility for the situation you found yourself in. Describe what you did and what you learned from it as well as any changes you would make in your reaction were you to experience such a situation again.
(Pattakos, 2004)

**Authenticity:**
**Description:** This character strength, also known as ‘integrity’ and closely related to ‘honesty’ (see CSV, Peterson & Seligman, 2004) implies being true to one’s real self rather than faking. In addition, Khatami, Doke & Boyer (1990) distinguish it from ‘automatic self’, which conforms rather than being true to one’s own motives and mission.

**Background:** “At one level, authenticity involves owning one’s personal experiences, be they thoughts, emotions, needs, wants, preferences, or beliefs, processes captured by the injunction to “know oneself”. The exhortation “To thine own self be true” further implies that one acts in accord with the true self, expressing oneself in ways that are consistent with inner thoughts and feelings.” (Harter, 2005, p. 382). It is important to point out, that being authentic includes a responsibility to act sensitively towards others.

**Evidence-Base:** Both in **Adolescence** as well as in adulthood, **Authenticity** is connected with psychological benefits such as self-esteem, **Hope**, positive relationships, and more positive moods and emotions (Harter, 2005).

**Example:** Fostering **Authenticity** can be done by validating the person. In case of an admirable deed, parents can say “you must be very proud of yourself for what you did” (Harter, 2005, p. 391). They are thus child-centred rather than giving their own value judgement.

**Exercise:** Khatami et al. (1990) developed a cognitive and meaning worksheet which captures the automatic versus the authentic self. It supports clients in their goal setting and problem-solving towards achieving authentic living.

Use this worksheet adapted from Khatami et al. (1990) for your own challenges/PPD. Having reflected on its strengths and possible pitfalls in your Reflective Diary, use it with your clients applying the deeper understanding gained from your own exercise!
Table 3: Cognitive and Meaning Worksheet adapted from Khatami et al. (1990)

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>AUTOMATIC SELF</th>
<th>AUTHENTIC SELF</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. at home trying to work on a paper</td>
<td>e.g. admonishing myself for my lack of work ethic</td>
<td>e.g. congratulating myself for each step in the right direction</td>
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</table>

Borderline Personality Disorder (BPD):

Description: BPD is a “pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning in early childhood and present in a variety of contexts (Kuo, Korslund, & Linehan, 2006, p. 900).

Background: BPD is defined by DSM IV as “indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behaviour covered in criterion 5.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behaviour covered in criterion 5.
5. Recurrent suicidal behaviour, gestures, threats or self-mutilating behaviour
6. Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms” (Kuo, Korslund, & Linehan, 2006, p. 900).

Linehan’s (1993a; 1993b) Dialectical Behavior Therapy (DBT) uses exercises such as “Making Lemonade out of Lemons” (Linehan, 1993a; 1993b), i.e. reframing problems in a positive way (see example below). DBT is CBT-based with acceptance and spirituality added to foster

**Strengths** in clients’ lives. DBT’s affinity to Logotherapy has been discussed (Fabry, Sheikh & Selman, 2007). Having been formulated before the arrival of Positive Psychology, it clearly belongs to the **Strengths**-based therapies.

Evidence-Base: SPC found strong research support for DBT and modest evidence for Schema-focused Therapy. Other approaches yielded controversial evidence.

NICE guidelines recommend the following evidence-based steps, including DBT:

Table 4: Summary of NICE Guidelines (2009) for Borderline Personality Disorder

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Treatment</th>
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<tbody>
<tr>
<td>During assessment, explain clearly the processes involved, using non-technical</td>
<td>Before offering treatment to someone with BPD, written material about what treatment is being considered needs to be provided to the person in</td>
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</tbody>
</table>
When considering a psychological treatment, consider the following: the choice and preference of the service user, the degree of impairment and severity of the disorder, the person’s willingness to engage with therapy and their motivation to change, the person’s ability to remain within the boundaries of a therapeutic relationship, the availability of personal and professional support.

Ensure the following service characteristics are in place: an explicit and integrated theoretical approach that is agreed between the service user and the multidisciplinary team. Consider twice-weekly psychotherapy sessions, although the frequency should be adapted to the person’s needs. Psychological interventions should not be less than three months in duration.

For women with whom reducing recurrent self-harm is a priority, consider a comprehensive dialectical therapy (DBT) programme. Monitor the effect of treatment on a broad range of outcomes, including personal functioning, drug and alcohol use, self-harm, depression and the symptoms of BPD.

DBT has been researched extensively (Linehan, 1993a, 1993b), with good evidence. 

**Example:** “’Making lemonade out of lemons’ requires that the therapist take something that seems apparently problematic and turn it into an asset. The idea is similar to the notion in psychodynamic therapy of utilizing the patient’s resistances: The worse the patient acts in therapy, the better it is. If problems did not show up in the therapeutic encounter, how could the therapist be helpful? Problems in everyday life are opportunities to practice skills. Indeed, from the point of view of practicing skills, not having problems would be a disaster, since there would be nothing to practice on. Suffering, when accepted, enhances empathy, and those who have suffered can reach out and help others. A variation here is that the patient’s greatest weaknesses are ordinarily also her greatest strengths (e.g. her persistence in ‘resisting’ change is just what will keep her going until changes are made)...the strategy cannot be used in a cavalier manner. Its effectiveness rests on a therapeutic relationship where the patient knows that the therapist has deep compassion for her suffering. In that context, however, the strategy can be used lightly and
with humor. When I conduct skills training, for instance, patients soon realize that I may rejoice over even the worst crisis as an opportunity to practice or learn a skill. The incongruity in my response (“Oh, how wonderful!”) to a patient’s distress (“I got fired”) forces the patient to stop and take in new information (i.e., this is a chance to practice interpersonal effectiveness, emotion regulation, or distress tolerance skills, depending on the current skill module). The skill of the therapist is in finding the silver lining without denying that the cloud is indeed black.” (Linehan, 1993a, pp. 216-217).

Exercise: Following the above example choose a perceived tragedy and find the good in it (reframing; see also ten positive things exercise below under Work)

Bravery:

Description: Also known as ‘valour’, Bravery means overcoming one’s fears voluntarily and in full awareness of the risks involved in order to serve a higher goal such as rescuing others, becoming a more mature person when exposing oneself to one’s own foibles, and acting according to one’s convictions despite personal dangers involved (see example below).

Background: Logotherapy helps clients become brave and stand up for their convictions in order to live by their Values* and thus live more authentic lives (see Authenticity*). Positive Psychology’s CSV lists Bravery as one of the 24 character strengths. It enables people to become whistle blowers or becoming committed to others and/or higher causes, overcoming fears of physical, economical, psychological and social harm (Peterson & Seligman, 2004). CSV distinguishes between physical (possible loss of life and limb), psychological (potential danger to the self), and moral Bravery (possible threat to ethical integrity).

Evidence-Base: In psychotherapy, courage is one of the Strengths* fostered (e.g. Seligman, 2005). It is part of Coping* (Furnham & Akande, 1997) with its strong evidence-base (see below).

Example: Dr Ungar writes:

Some thirty years ago, as a young psychiatrist, I was living and working in a communist eastern European country. Our contacts with the western countries were limited, and so I was overjoyed when a friend of mine, living in Austria, managed to smuggle one of Dr Viktor Frankl’s books to me... After reading the book, I was very thrilled, and I wanted to contact the author to express my appreciation... Anyway, I took the courage, and I was almost in disbelief, when, at the other end of the line, a friendly voice greeted me, and Dr Frankl welcomed me to meet him in Vienna. At the time, the rule in my country of origin was that every professional communication with foreigners had to be reported in advance to the health authorities, who issued a permit and gave instructions on what was allowed to say, and what was forbidden to discuss. Indeed, to ask for such permission seemed like a “double-edged sword” to me, as even if the permission was granted, I was running the risk of being labelled as having “suspicious communications”. Thus, I calmed myself by telling myself: “This will not be a professional, but a friendly communication... The visit was very friendly. Dr Frankl was very attentive, and I had the opportunity to ask many questions... On my way out, he kindly introduced me to a journalist, who also had an appointment... Elated with the meeting, I forgot to warn him about secrecy – not to mention anything about our meeting... However, it was too late. He could not reverse the time, and prevent that my name already became mentioned in a local newspaper as a psychiatrist visiting from the other side of the “Iron Curtain”. Dr Frankl, as a survivor of three concentration camps, knew very well the feelings of angst, fear, and terror, some of what I was experiencing in that moment. Over the phone, he gave me a few encouraging words.
...soon after I returned from Vienna, I was summoned for a party cross-examination. At that time, the communist party still had immense powers. They could suspend, or terminate anyone’s job at any time, and humiliate them in any way they wanted. Thus, I went to this meeting, my heart beating faster and faster, and my whole body trembling with cold sweat...I suddenly recalled what Dr Frankl had told me over the phone: ‘Yes, the communists are stronger than you are. They can crush, humiliate, or fire you – they can make a respectable psychiatrist ‘insane’. However, their position of power does not alter the fact, that, despite all that threat, not they, but you are doing the right thing. And because of that, ultimately, you will prevail.’

...I started to feel the power of truth beyond those words. In a few moments, my fear disappeared, and I felt courage instead: ‘Yes, the communists can humble me... but this does not change the fact that ‘I am right,’ and that I can be, if not ‘proud,’ but at least aware that I am suffering for ‘doing the right thing.’”

So, I arrived to the seventh floor, and approached the “lion’s den.” But, by that time, I was not a defensive, scared “servant;” or a “repentant sinner.” On the contrary: I had the courage to endure the situation and even the pluck to turn it into a humble but humorous confrontation.

Maybe it was this attitude; or something else – anyway the communist examiners remained benevolent with me, and after giving some “fraternal advice” we said good bye to each other in a “friendly tone.” (Mendez, 2004, pp. 7-9).

Exercise: Discuss with a colleague how to apply the following in your work with clients:

“Bravery can be promoted by practice (moral habit), by example (modeling), and by developing certain attributes of the individual (self-confidence) or group (cohesion).” (Peterson & Seligman, 2004, p. 221).

Common Denominator:

Description: This technique aims at finding a solution in an apparently unsolvable quandary.

Background: Frankl (2000) writes: “Ilse Aichinger, today a well-known writer, came to me, when she was still a medical student. She was in a dilemma, having to decide whether to continue writing the novel she had started (the one that made her famous) or to remain in her medical studies. After a long talk, she decided that it was less of a problem to interrupt her studies temporarily than to postpone the completion of the novel. The common denominator was the question: Which is more at risk if interrupted?” (Frankl, 2000, p. 67). “This technique of bringing to light a common denominator can be used to good purpose where comparison of ‘goods’ rather than preferences of values is required.” (Frankl, 1986, pp. 278-279). Thus, there is one underling value with at least two different ‘goods’ to choose from which are mutually exclusive. Once the underlying value is identified, listing the pros and cons on each side reveals which option is the better one for this person at this time.

Evidence-Base: This is in essence a Problem Solving strategy. The following meta analyses suggest that problem solving therapy (PST) can be a salient type of intervention in a variety of contexts.

For example in terms of health, fifty two studies in a review by Hill-Briggs and Gimmell (2007), note that problem solving had a positive impact upon diabetes mellitus management. Similar findings have also been noted in a review by Cuijpers et al (2007) finding that PST is an effective intervention for depression (see also a meta analysis by Gellis and Kenaley, 2008). A review by Lui et al (2005) concluded that PST strategies can have a positive impact upon supporting care givers of people suffering from stroke damage and a short term reduction in care giver depression, improving family problem-solving, positive problem orientation and caregivers’ rates of depression, preparedness, vitality and coping. In a review by Townsend et al
problem-solving therapy had better outcomes than control treatments for depression, hopelessness and problems among deliberate-self-harm patients.

Example: A young man has become paralysed and finds it hard to see meaning in life due to his disability. His doctor asks him to create a “balance sheet. Against the evil of his illness there were a sizable number of goods which could give meaning to his life, including a happy marriage and a healthy child. His handicap was not plunging him into economic ruin, since he had been granted a pension. He came to realize that his kind of paralysis would at most have ruined the career of a professional boxer – and even for such a man need not necessarily have destroyed the whole meaning of his life.” (Frankl, 1986, pp. 278-279).

Exercise: Think of a time when you were not sure which option to choose (this may be the situation you are in now, e.g. deciding whether to do this exercise now, carry on reading or get up and do something completely different such as going out, calling a friend etc.). Find a value that is important to you in this situation, such as personal-professional development, work-life balance, etc. and adapt Ilse Aichinger’s summary question (see above) accordingly. Once you have decided, make a commitment to stick to your decision, evaluating it later to see whether you are satisfied with the result and which adaptations, if any, to make.

Coping:

Description: Coping mechanisms are thoughts, behaviours, and emotions that help the person function in a challenging situation, i.e. in situations where the demands are (perceived as being) somewhat greater than the person’s abilities.

Background: Lazarus & Folkman (1984) describe problem- and emotion-focused coping as the two main ways of dealing with a demand/ability mismatch as described above. Park & Folkman (1997) added the meaning component to this model, thus arriving at the following meaning-making coping model (Park, 2005, p. 709):

Figure 2: Meaning-Making Coping Model (Park, 2005, p. 709).
Evidence-Base: **Coping** has a strong evidence-base (for a summary, see Folkman & Moskowitz, 2004).

*Example:* By summarising recent events, a person realised why she was feeling so exhausted. Realising that demands had been greater than in a long time, this helped explain and normalise her feelings of exhaustion.

*Exercise:* Apply the above model to one of your clients’ situations and/or your own. In what way is it helpful? Would you suggest any additions/amendments? Why?

**Counting One’s Blessings:**

*Description:* In Positive Psychology, this is a technique which requires the person to “Write down three things that went well before you go to sleep at night” (Sutton, 2009).

*Background:* In Logotherapy, the principle of focusing on the positive and valuable aspects of life is called **Derefection** (Frankl, 2000). Frankl conceived it as an antidote to **Hyperreflection**, i.e. focusing too much on problems and handicaps. In 2009, Seligman reported, that **Counting One’s Blessings** is an intervention that he started “eight years ago, and he says that (unlike a lot of interventions from ‘traditional psychology’) it is addictive” (Sutton, 2009). Its potential of enhancing life through reflection on what’s good and right enhances **Gratitude**, which in itself improves subjective well-being (Bono, Emmons & McCullough, 2004).

*Exercise:* Count your blessings every night in writing, and see for yourself whether it has a similarly positively addictive effect for you as for Prof Seligman. In addition, compare and contrast it with **Expressive Writing** exercises – can you find certain circumstances, where you would prefer one over the other, and why? Can they complement each other? If yes, in what kind of situations could that be the case? When would consecutive usage be more beneficial, and in which situations would you suggest using both concurrently?

**Creativity:**

*Description:* **Creativity** can be defined as “Thinking of novel ways to do things” (Peterson & Park, 2004, p. 437) including art. It helps people cope with life and gives them **Meaning**.

*Background:* In Logotherapy, expressing creative values by creating something or doing a deed is one way of finding meaning together with **Experiencing something/-one** and **Attitudinal Change** when faced with unchangeable situations (see **Meaning Triangle**). In Positive Psychology, Sternberg and Lubart’s (1992) ‘investment theory of creativity’ postulates, that creative people “buy low and sell high” “…in the field of ideas… they…adopt poorly developed ideas which are unpopular or unfamiliar but which have growth potential, invest creativity in these and develop them into ‘creative products’” (Carr, 2004, p. 154). Six factors need to come together in this model. They are – “intellectual abilities, .. sufficient knowledge about the field, … capacity to think in novel ways… globally (about the big picture) as well as locally (about details), … sensible risk taking” and “tolerance for uncertainty… intrinsic motivation, … a supportive environment…” (Carr, 2004, p. 154)
Evidence-Base: Simonton (2004) found that “under the right conditions, exposure to traumatic or difficult experiences early in life can make a positive contribution to the development of creative potential …” (Simonton, 2005, p. 193).

Example: The therapist looked through the list of Character Strengths and Virtues (Peterson & Seligman, 2004). Creativity was one of the strengths the client had shown by finding ways of distracting themselves with creative activities when they experienced an urge to engage in unhealthy behaviours. Identifying such creative problem-solving and labelling it as such helped the client apply these Coping* strategies in other challenging situations as well as in reaching their Goals*.

Exercise: Explore with your clients how they have managed to live with their challenges. Identify their Creativity in the way they have accommodated it. Now describe the skills they used in doing so. These skills are part of their repertoire of Strengths*! Acknowledging and celebrating them will help in applying them in a constructive way to the clients’ Goals*.

Depression:
Description: Depression* is part of the neurotic triad (Frankl, 1985; see entry on Addiction*).

Background: DSM IV-TR (APA, 2000) diagnostic criteria for major depressive episode are: For nearly every day for two weeks, one key symptom and in total at least five symptoms are present, in addition to great distress or difficulties in social, vocational or educational functioning:

Key symptoms:
- Low mood
- Greatly reduced interest or pleasure in a majority of daily activities (anhedonia)

Ancillary symptoms:
- Tiredness or lack of energy
- Increased or decreased appetite or weight
- Increased or decreased amount of sleep
- Psychomotor agitation or retardation
- Low self-esteem or strong guilt feelings
- Poor concentration, difficulty making decisions
- Suicidal ideation or attempts.

Frankl describes Logotherapy’s contribution to tackling Depression*: “We have already said that man is free to take a position on his psychological destiny, that there is a ‘pathoplastic’ factor involved – meaning that he can shape his destiny and decide how he will react to the constitutional disease … aimed to change the patient’s attitude towards her disease as well as towards her life as a task” (Frankl, 1986, p. 200). The following steps support clinicians in their quest to help their clients, utilising Attitudinal Change*:

1. Explore the patient’s current situation, and understand the cause of the suffering they experience;
2. Look for roots of the suffering and see where there are realistic limitations;
3. Notice also the strengths and possibilities;
4. Notice the unhealthy attitude which increases the suffering and try to change… [it];
5. Bring the findings to the awareness of the patient and discuss them openly;

Development of Gratitude* is another way of helping clients improve their situation.
Evidence-Base: SPC recommends the following therapy modalities with strong evidence base for Major Depression: Behaviour Therapy, Cognitive Therapy, Cognitive Behavioral Analysis System of Psychotherapy, Interpersonal Therapy, Problem-Solving Therapy, and Self-Management/Self-Control Therapy. A number of other treatment modalities with modest research support are Acceptance and Commitment Therapy, Behavioral Couple Therapy, Emotion-Focused Therapy, Reminiscence/Life Review Therapy, Self-System Therapy, and Short-Term Psychodynamic Therapy.

NICE guidelines recommend:

Table 5: Summary of NICE Guidelines (2009) for Depression

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Treatment</th>
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<tbody>
<tr>
<td>The recommendations in this guideline are presented within a stepped care framework that aims to match the needs of people with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances.</td>
<td>In mild and moderate depression, consider psychological treatment specifically focused on depression (problem-solving therapy, brief CBT and Counselling) of 6 to 8 sessions over 10 to 12 weeks. Offer the same range of treatments to older people as to younger people. In psychological interventions, therapist competence and therapeutic alliance have significant bearing on the outcome of the intervention. Where significant comorbidity exists, consider extending treatment duration or focusing specifically on comorbid problems.</td>
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<tr>
<td>Psychological intervention does not occur until step 2 (mild depression) of the model (5 steps in total).</td>
<td>Psychological treatments involved during step 3 of the model (moderate to severe depression) include CBT as the treatment of choice. However, consider interpersonal psychotherapy (IPT) if the patient expresses a preference for it or if you think the patient may benefit from it. Treatment should consist of 16 to 20 sessions over 6 to 9 months. Consider CBT or indeed IPT for patients with moderate or severe depression who do not take or refuse antidepressant treatment. Consider CBT for patients with severe depression for whom avoiding the side effects often associated with antidepressants is a clinical priority or personal preference. For patients with severe depression, consider providing 2 sessions of CBT per week for the first month of treatment. Where patients have responded to a course of individual CBT or IPT, consider offering follow-up sessions, typically 2 to 4 sessions over 12 months.</td>
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<tr>
<td>CBT should be considered for patients with recurrent depression, who have relapsed despite antidepressant treatment, or who express a preference for</td>
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psychological interventions; patients with a history or relapse and poor or limited response to other interventions; patients who have responded to another intervention but are unable or unwilling to continue with that intervention, and are assessed as being at significant risk of relapse.

The way to combine CBT with Positive Psychology and/or Logotherapy is to help clients take a stance towards their suffering (e.g. Fabry et al, 2007). **Dereflection** can help increase perception of **Strengths** and **Gratitude**. Increasing the value-base helps clients develop a **Parallel Value System** with various important goals. This aids relapse prevention (see **Parallel Value System**).

**Example:** “Mrs S., a mother of two, had been hospitalised in a clinic three times for depression... the husband had sent the children to a boarding school ... the children had been central to her life, and now she would not be able to see them often. I was afraid that the emptiness of the house and lack of a task would create an existential vacuum in her. It would have required great strength of will and inner security to build up a new field of activity by herself – more than could be expected from a patient recovering from a depression. I suggested keeping her in the clinic until she had been given time to think about restructuring her life...But the doctor was convinced she was well enough... Three weeks later Mrs S. was brought back to the clinic. She had taken an overdose of sleeping pills and been saved in the nick of time... Leisure and relaxation had not been sufficient to fill her life with meaning, especially since what had been most meaningful to her in the past had been removed. After several sessions it became clear that Mrs. S. had a fondness of animals second only to her love for her children. She succeeded in finding a job in the public zoo. She enjoyed her new work... One Sunday I went to visit Mrs. S. at the zoo and saw from the distance how she laughed with the children. I went home convinced that her follow-up had been successful.” (Lukas, 1986a, pp. 56-57).

**Exercise:** In parallel to having to accept endogenous Depression, find an area of fate that is causing you grief. Using the steps above (Mendez, 2004), develop your stance towards this fate, thus exercising your freedom to respond in your own, unique way.

**Dereflection:**

**Description:** Technique of consciously focusing away from problems and onto valuable events and **Strengths** (Frankl, 1985; Lukas, 1986a) in order to balance out any negative bias that may be present.

**Background:** This technique of focusing on the positive and valuable aspects of life was developed by Frankl in order to bring a balance into clients’ otherwise at times biased and rather gloomy views. **Dereflection** “is intended to counteract this compulsive inclination to self-observation.” (Frankl, 1986, p. 255). Frankl tells the enlightening story of “the centipede who ran very well until he decided one day to observe just how he ran. The more he became conscious of the process, the more difficult it was to function, and finally he could only lie in a ditch in despair.” (Frankl, 1986, p. 255). **Dereflection** is also used in other approaches under terms such as Solution-Focused Therapy’s problem-free talk (De Jong & Berg, 1998; see also Graber, 2004...
on the many commonalities between Solution-Focused Therapy and Logotherapy) and CBT’s Strength*-focused approach (e.g. Kuyken, Padesky & Dudley, 2009).

Evidence-Base: The evidence suggests that helping clients focus away from the self (e.g. Chaker, Hofmann, & Hoyer, 2010) and onto perceived valuable events helps them in many ways (Peterson & Seligman, 2005).

Example: A stroke sufferer became afraid of being dependent on others. One day she had the thought of how, being a health professional herself, she would speak with a patient in this situation, so she said to herself: ”Let us put the worries aside for a moment and see what next step you may want to take”. This helped her develop a new attitude away from Hyperreflection* and towards healing (van Pelt, 2008, p. 34).

Exercise: In a role-play with a colleague, choose a situation one of your clients is in and help the ‘client’ limit their freedom of speech for the duration of the session by practicing acknowledging and emphasising the valuable things in their life.

Despair:
Description: Despair is part of the group of feelings more readily experienced by pessimists in contrast to optimists (e.g. Carver & Scheier, 2005). Associated with avoidance Coping*, it is less adaptive and functional than its positive counterparts such as Hope* and Humour*.

Background: Logotherapy suggests that Despair is Suffering without Meaning D=S-M (see Frankl, 1996). Once a person can ‘make sense’ of suffering, the suffering is transformed into dedication, love, Hope*, sacrifice etc., e.g. when parents see their suffering sleep-deprivation as a meaningful part of their duties to care for their sick child.

“Only a human being, who has idolised something, can despair.” (Frankl, 1996, p. 226; translation by first author). Otherwise, the person will be sad about not being able to fulfil certain ambitions or desires and then move on to fulfil their potential in other ways.

Evidence-Base: See entry on Hope*.

Example: “It is sad, when a woman, who wishes to get married and have children, has to stay single. However, this can only be a reason for despair for a person, who idolises such goals, and who makes the fulfilment of these wishes a condition ‘sine qua non’ for the worth of their life” (Frankl, 1996, p. 226; translation by first author). Instead, the woman can be helped to fulfil her desires in another way, e.g. by looking after children in a very dedicated fashion.

Exercise: When clients come to psychotherapy, they often despair over life’s blows and try to make a case for seeing meaning only under certain conditions, e.g. life being only meaningful with a husband and children (see example above). However, it is the psychotherapists’ task to help clients accept their life tasks and recognise/reframe this as a challenge (See also exercise under Meaning Transformation*). Techniques such as EFT* with their ability to tackle “self-limiting beliefs” (Falk, 2010, personal communication) can facilitate coming to terms with such fates (see also Fate-Freedom Balance*).

Disability:
Description: Disability relates to the fourth aspect of the Social GRRAACCEESS developed by Burnham (1993; see below under Diversity*). This aspect of human experience has been associated with lack and suffering.

Background: In Logotherapy, the human being is considered to have a sane and whole inner core which is not affected by any illness or disability. It can be covered by the somatic and
psychological problems, but once the situation has slightly improved, the inner core comes to the fore (Frankl, 1996). This means that it does not matter that the clients have a syndrome (e.g. autism, dementia, etc.) as long as the clinicians do not treat them as if they were the syndrome, i.e. “the therapist needs to look behind the façade of disability and discover the unique person that lives within this outer shell of handicap” (Fabry, 2004, p. 6). “The spiritual [dimension of the] person can be disturbed from the psychophysical [dimension] but not destroyed” (Frankl, 1996, p. 152; translation and additions by the first author).

**Evidence-Base:** Both the American Psychological Association (APA) and British Psychological Society (BPS) instruct their authors to avoid biased language and describe clients as with syndrome rather than e.g. the schizophrenic. This confirms the widespread importance attributed to the unique person coming for psychotherapy. It is encouraging that this is seen as much more than political correctness. It is rather an expression of the fundamental value of the human being above and beyond the challenges this human being faces (BPS, 2004; APA, 2009).

**Example:** A client with a Learning Disability saw a Paediatrician and played ‘doctor’ by using the toy phone in the room to make ‘appointments’. “She’s not all that thick”, the paediatrician commented with a smile after the consultation. What had happened was that the client had used the situation creatively despite her Learning Disability. The unique person had peeked out from behind the mask of the disability (Fabry, 2004).

**Exercise:** Becoming disabled can lead to personal growth (see e.g. Elliott, Kurylo, & Rivera, 2005) and a ‘new lease on life’. Explore in your own life and the life of your family, friends, colleagues and clients signs of this growth post-Disability. What lessons can you draw from these accounts?

**Diversity:**

**Description:** Being aware of differences in Gender, Race, Religion, Age, (Dis-)Ability, Culture, Class, Ethnicity, Education, Sexuality, Spirituality, i.e. the so-called Social GRRAACCEESS (Burnham, 1993) is a pre-requisite to supporting clients in a user-friendly way. Awareness of one’s own difference from others is also important for the clinician.

**Background:** Coming from a humanistic tradition, Logotherapy accepts the human being as it is, no matter what differences there may be. As the core of the human being is seen as central (see entry below under Person*, point 4), all the outside attributes pale and become only insofar important, as they may be (perceived as) a barrier to meaningful living.

Positive Psychology has developed this theme further by conceptualising Diversity as one of the Strengths* (Lopez, Prosser, Edwards, Magyar-Moe, Neufeld & Rasmussen, 2005). For clinical practice, this awareness and research base is vital as it may well prevent the clinician making uninformed assumptions (see Evidence-Base below).

**Evidence-Base:** There is growing evidence for the fact that terms and constructs are culture-sensitive. Thus, Chang (1996) found when examining optimism, pessimism and coping in Asian Americans and Caucasian Americans, that ‘pessimism’ was correlated with good adjustment in Asian Americans and not in Caucasian Americans.

**Example:** An American businessman, Woody, was at the pier of a small Mexican village when a boat with just one fisherman docked. Inside the boat were many pounds of large gulf shrimps. The American complimented the Mexican on the quality of his catch, and asked about the mesh of his cast net. “Why is the mesh so large? Couldn’t you catch more with a tighter weave?” Hector, the fisherman, replied, “I catch what I need, señor. And the net, the net is a fine net. I was taught how to weave this net by my father, who was taught by his father. I work on the net every day to keep it strong.”
Woody then asked how long it took to seine for his catch. Hector replied, “Only a little while.” The American questioned, “So what do you do with the rest of your time?” The Mexican fisherman said, “I sleep late, I pray, go shrimping for a while, play with my children, take siesta with my wife, Maria, examine and repair the net, stroll into the village each evening to sip wine and play guitar with my amigos. On Sundays, I go to mass and spend the rest of the day with la familia. I have a full and busy life señor. I am very happy.” After hearing the fisherman’s account of his week, Woody scoffed, “I am a Harvard MBA and could help you be more successful. You should use a net with a smaller weave and spend more time fishing and, with the proceeds, buy a bigger boat with a larger net you could troll for many miles. With the profits from the bigger boat you could buy several boats; eventually you would have a fleet of boats. Instead of selling your catch to a middle man, you would sell directly to the processor and then open your own plant. You would control the product, processing, and distribution. You would need to leave the small coastal fishing village and move to Mexico City, then Houston and then Los Angeles. There you will run your expanding enterprise.” Hector was somewhat taken aback by the complicated plan and asked, “But señor, how long will all this take?” Woody replied, “Fifteen to 20 years.” “But what then, señor?” The American laughed and said, “That’s the best part. When the time is right, you would sell your company stock to the public and become very rich; you would make millions.” “Millions, señor? Then what?” Hector questioned. The American said, “Then you would retire, move to a small coastal fishing village where you would sleep late, pray, fish a little, play with your grandkids, take a siesta with your wife, stroll in the village in the evening to sip wine and spend time with la familia.” (Lopez et al., 2005, pp. 700-701)

**Exercise:** At the start of peer or group supervision, describe yourself on the dimensions of the Social GRRAACCEESS (Burnham, 1993, see above). Now do the same for your ‘client’ for the same description. What do you notice (e.g. status, power, mutual understanding, assumptions etc)?

**Dreams:**

**Description:** Dreams can help a person in their search for meaning, as in Dreams, everything is possible and so otherwise seemingly un-reachable ideas and aims can be reached without any barriers.

**Background:** Individual meaning of Dreams* may be explored to understand personal situations and tasks. Mendez (2004) states “Dreams can be used in therapy to facilitate the treatment process” (Mendez, 2004, p. 187). Socratic Dialogue* is the technique of choice in this endeavour, helping the client to discover or confirm meanings, or help them to see themselves in a more capable, competent and successful light etc.

**Evidence-Base:** See evidence under Socratic Dialogue*.

**Example:** A retiring gentleman dreamed of a difficulty in a crossword puzzle, which he then solved. Using the dream as an analogy to his current difficulty of coming to terms with his imminent retirement, the therapist was able to help the man gain an understanding of how to best approach this transition (Isaacson, 2008).

**Exercise:** Have you or one of your clients ever had a dream which seemed to be helpful in dealing with a life situation? Have you/your client had any day dreams, may be of a nature similar to Martin Luther King’s famous “I have a dream...”? Please take a moment to develop your own completion of Martin Luther King’s “I have a dream_____”, noting some key words in your Reflective Journal. Now take one step towards fulfilling this dream with a commitment to follow up on it and keep at it until you have reached a realistic version of this dream. Remember: “A mature person is not discouraged by disappointments. He perseveres until he reaches his goal.” (Anonymous, cited in Weiss, 1997, p. 85)
Eating Disorders:
Description: Severe, pervasive and persistent disturbance of eating habits as well as cognitions and perceptions around eating and body image.
Background: In summary, DSM IV criteria are:
Anorexia nervosa:
- Body weight below normal weight for age and height
- Despite being underweight, there is a great fear of gaining weight
- Disturbed experience of body weight or shape, or body weight or shape having great unusually strong influence on self-evaluation, or low weight is not taken serious
- Absence of menstruation for at least three cycles in females
- Restricting or binge-eating-purging types are specified

Bulimia nervosa:
- Binge eating episodes, where unusually large amounts of food are eaten in a certain amount of time plus feeling of lack of control over eating during the episode
- Trying to prevent weight gain by e.g. self-induced vomiting, laxative misuse, diuretics, medications, fasting or excessive exercise
- The above behaviours occur at least twice a week for three months
- Body weight or shape have an unusually strong influence on self-evaluation
- Does not only occur during episodes of anorexia nervosa
- Purging or non-purging types occur

“A great deal has been written about dieting, anorexia nervosa, and bulimia. The literature suggests that one of the personality characteristics, a deficit in impulse control, may be a risk factor for bulimic pathology…” (Zwang Hirsch, 2008, p. 3). Logotherapy helps clients realise that their unhappiness with their life situation led them to their Eating Disorder. They then (re-)discover their Values* which helps them replace their dysfunctional eating behaviours with activities directed towards acting on and realising their Values* (Zwang Hirsch, 2008).
Evidence-Base: SPC distinguish between Anorexia and Bulimia Nervosa as well as Binge Eating and Obesity. SPC reports strong research support for family-based treatment in Anorexia Nervosa, CBT having yielded modest to controversial research support. For Bulimia Nervosa, the SPC suggests CBT and Interpersonal Psychotherapy (strong evidence), and Family Based Treatment with modest research support.
NICE guidelines recommend:
Table 6: Summary of NICE Guidelines (2004) for Eating Disorders

<table>
<thead>
<tr>
<th>Care across all conditions</th>
<th>Management of Physical Aspects</th>
</tr>
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<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td>If patient is suffering from laxative abuse then a gradual reduction should be advised. Patients who are vomiting should have regular dental reviews along with dental advice on how to maintain good standard of oral hygiene, refraining from physical activity that may increase the likelihood of falling is also important as people with eating disorders are at a higher risk.</td>
</tr>
<tr>
<td>Include physical, psychological, and social needs. The level of risk to the patient’s physical and mental health should be monitored as treatment progresses, for example, as weight gain is achieved. GP’s should take care of initial assessment in Primary Care, however, where management is shared between Primary and Secondary Care there needs to be agreement amongst professionals for the responsibility of monitoring. Agreement should be in writing and shared with the patient</td>
<td></td>
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<tr>
<td><strong>Support</strong></td>
<td><strong>Screening</strong></td>
</tr>
<tr>
<td>Patients and appropriate carers should be provided with education and information on the nature and course of treatment with the offer of self-help groups being made available. Professionals should be aware that many people with eating disorders are ambivalent about treatment and that it presents certain</td>
<td></td>
</tr>
<tr>
<td>Target groups are young women with low BMI compared with age norms, patients with menstrual disturbances or amenorrhoea, gastrointestinal symptoms, or any physical signs of starvation or repeated vomiting.</td>
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</table>
challenges in behaviour.

<table>
<thead>
<tr>
<th>Anorexia Nervosa</th>
<th>Assessment and Management</th>
<th>Psychological Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight and BMI should not be used as sole indicators of physical risk due to their unreliability. Clinical assessment over time is the appropriate procedure for assessment, including recording the rate of weight loss, objective physical signs and laboratory tests.</td>
<td>The majority of anorexia patients should be managed on an outpatient basis with a duration of at least 6 months. If there is significant deterioration in the patient during the psychological treatment or indeed there is not any significant improvement, then more intensive forms of treatment should be considered, for example, a move from individual work to combined individual and family work, or day care.</td>
<td>Therapies to be considered for treatment include. Cognitive Analytic therapy (CAT), Cognitive Behavioural Therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy and family intervention focused on eating disorders. Patient preference should be considered when deciding on a chosen therapy. The therapy should be aimed at reducing risk to the patient, but also encouraging weight gain and healthy eating, reducing secondary symptoms related to the eating disorder, and facilitate recovery.</td>
</tr>
</tbody>
</table>
Bulimia Nervosa

Psychological Interventions

Patients should be encouraged to follow an evidence-based self-help programme, with direct support from professionals to improve outcome.

Psychological Interventions

Cognitive Behavioural therapy for Bulimia Nervosa (CBT-BN), which is a specifically adapted form of CBT should be offered as a form of treatment with sessions lasting between 4 to 5 months. If patients refuse CBT or indeed there are no signs of improvement then alternative forms should be considered, such as, interpersonal psychotherapy. However, this form of therapy takes substantially longer to achieve results at around 8-12 months in comparison to CBT.

How can we enhance the treatments recommended above? Logotherapy and Positive Psychology help balance the above programmes by ensuring a Strengths* focus, enhancing that which has worked in the past, and Counting one’s Blessings*.

Example: A client’s father was coming for consultation for his daughter who suffered from Anorexia. Acknowledging the family’s hard work in re-feeding her was a turning point for this parent who up to this point had received rather negative feedback from professionals. In addition, the therapist highlighted the daughter’s Strengths*, which helped the father experience her from a more benign viewpoint.

Exercise: Zwang Hirsch (2008) writes: "When any substance is taken into the body regardless of its potential for harm or in excess of need, that substance is said to be abused. Individuals, who abuse substances in such a way, are addicts who become dependent upon a certain substance. In this case it is food." (Zwang Hirsch, 2008, p. 3). Compare this idea with what has been said regarding Addiction* above and here on Eating Disorders. Reflect on the commonalities and differences, discussing them with colleagues, supervisors etc. Note your observations in your Reflective Journal, such as that anorexia may be an Addiction* to not eating or to dieting rather than to food per se.
Emotional Freedom Technique (EFT)

Description: This relaxation technique was developed by the retired engineer Gary Craig, who simplified Dr Roger Callahan’s Thought Field Therapy (TFT). For another relaxation technique, see Logoanchor*

Background: In every therapy, cognitively based approaches need to be complimented by relaxation techniques aimed at experiential processing of situations. One such approach is EFT which involves tapping at certain body points which releases the tension and reduces the emotional impact of this particular situation, e.g. trauma. It is important to realise that it is a technique that can be easily integrated into practitioners’ existing work to assist emotional processing (see example below).

Evidence-Base: Emerging evidence on EFT has been accumulated by Church (2009; 2010), Church, Geronilla & Dinter (2009), Lubin & Schneider (2009), Wells, Polglase, Andrews, Carrington & Baker (2003), Brattberg (2008), showing promising results for EFT in increasing athletic performance, treating combat veterans’ Post Traumatic Stress Disorder, prisoners’ impulse control, specific phobias, and patients with a chronic condition.

Example: Prisoners who experienced EFT describe it as follows:

"I don’t resort to my old belief system... and I no longer feed on the chaos of prison life. EFT allows the old behaviour patterns to crumble."

"I’ve come to realize that my old communication style was very judgmental and full of fault finding. EFT empowers you to change your insight and core beliefs."

"...when we delved into the causes of alcohol and substance abuse, we discovered again and again that low self-worth is often at their root." (Lubin & Schneider, 2009, p.4).

Exercise: Access EFT material on http://www.emofree.com and practice it on one of your own challenges according to the instructions given, tapping the 7-8 points shown in the illustration. If possible, access an EFT practitioner to enhance the experience. Reflect on the impact and possible use in therapy.

Empathy

Description: Empathy is one of the key ingredients to developing and maintaining a good therapeutic relationship. CSV includes it in the discussions on compassion and Kindness* (Peterson & Seligman, 2005).

Background: Empathy is one of the three Rogerian core therapeutic stances (Rogers, 1995) as well as a general factor found in psychotherapy research (for a summary, see Zhou, Valiente, & Eisenberg, 2000). Whereas it shares a common basis with compassion or feeling for the other, compassion’s focus is on the equality of the relationship with the sufferer in typical existential fashion, bringing in the “personhood” of the therapist and viewing oneself “as fellow pilgrims” (Ingram, 2006, p. 229). Its essential components are connecting and identifying with others through mirroring, a common Spirit* and “knowledge of the human condition” (Cassell, 2005, p. 437). Through their compassion and Empathy, therapists model Empathy for the client, a concept also acknowledged in the analytic self-psychology tradition (Kohut, 1977; Mollon, 1997).

Compassion has little space in our industrialized world of neon signs... Self-pity is unhealthy, and psychotherapists must free clients from it and replace it by compassion that opens new and positive attitudes toward their affliction. They need to know what positive attitudes are (Lukas, 1986a, p. 63).

Evidence-Base: Therapists’ Empathy is an important, well-researched aspect of psychological therapy, accounting together with other generic therapist factors for a large amount of change in therapy (Lambert & Ogles, 2004). There are various self-report measures for Empathy, such as
those relying “on picture-stories, on questionnaires, and ... simulated experimental situations” (Zhou, Valiente, & Eisenberg, 2000, p. 270). In addition, there are other-report measures and observations of facial, gestural, vocal indices as well as physiological measures. As people display this emotion in a variety of ways, some keeping their emotions more to themselves than others, a multi-method approach to measuring this construct is vital (Zhou, Valiente, & Eisenberg, 2000).

Example: A client had been upset by the parents’ style of upbringing. With time, distance and Empathy from the therapist, this young adult became aware of the many challenges the parents had to face during their children’s early years. This in turn gave rise to compassion, enabling a closer, more accepting and rewarding relationship for both sides.

Exercise: Role play starting a therapeutic relationship by focusing on understanding the client’s reality from their position, putting aside any other agendas. Your guiding question is “...what it is like to be inside the client’s reality”? (Ingram, 2006, p. 27).

Eulogy:
Description: Technique of asking clients/patients to write their own eulogy in order to help them focus on what they wish to be remembered for, thus helping to identify central Values they hold (Pattakos, 2004). Once this is accomplished, practical problem solving can help realise these identified Values. Contraindications include highly depressed, suicidal clients/patients.

Background: Paradoxical Intention, the basic principle, on which this technique is based as it is making light of something that most people are afraid to think or talk about, is used in this technique to help clients identify their core Values. Use of Humour (see example) and exaggeration facilitate a more flexible view of one’s life. It is similar to Seligman’s deathbed test: “I wish I had spent more time ________” (Peterson & Seligman, 2004, p. 17). They add: “It is doubtful that anyone would say “visiting Disneyland” or “eating butter pecan ice cream.”, thus showing how such exercises can help identify one’s Values!

Evidence-Base: As the underlying mechanisms are Paradoxical Intention and problem solving (i.e. the problem of what is important for the client to focus on), see evidence-base for Paradoxical Intention and Common Denominator.

Example: A middle-aged woman described how she wished to be remembered for her shouting, complaining, and finding fault in anybody and anything! Subsequently, she laughed so much at her own imperfections that she couldn’t shout and complain any longer!

Exercise: Try out this exercise, writing down your own Eulogy and your completion of the deathbed test in your Reflective Journal.

Exercise:
Description: Physical exercise (as well as a balanced diet) is important for maintaining and regaining a healthy and wholesome life.

Background: Research has shown that regular physical exercise can be as effective as anti-depressant medication (for a review, see Dienstbier & Zillig, 2005).

Evidence-Base: Research on Helplessness shows the importance of developing frustration tolerance and Resilience (Seligman, 1975; see also Dienstbier & Zillig, 2005).

Example: An advertisement in a London newspaper read “Unemployed. Brilliant mind offers its services completely free; the survival of the body must be provided for by adequate salary” (Frankl, 1986).

Exercise: Taking the above example to heart, plan how to discuss physical Exercise with your
clients as part of ensuring the healthy “survival of the body” and nurturing the “Brilliant mind”!

**Existential Analysis:**

**Description:** “To contrast his approach from Freud’s, Frankl introduced the term *Existenzanalyse.* *Existenzanalyse* is an assessment of the person within his or her existential paradigm in order to help that person to deal with problems in the most responsible way possible.” (Graber, 2004, p. 39).

**Background:** “I call existential analysis this psychotherapeutic treatment method which wants to help him find meaningful moments in his existence, detecting value opportunities. Of course such an existential analysis asks for a conception of man, in which meaning and value and spirit have a place, such a place which they ought to have. In one word, such a conception of man entails being spiritual, free and responsible – responsible for the realisation of values and for fulfilment of meaning: The concept of a meaning oriented human being.” (Frankl, 1999, p. 142; *translation by the first author*). **Existential Analysis** “… is particularly concerned with making men conscious of their responsibility – since being responsible is one of the essential grounds of human existence. If to be human is … to be conscious and responsible, then existential analysis is psychotherapy whose starting-point is consciousness of responsibility.” (Frankl, 1986, p. 25; see also **Existential Issues**).

**Existential Analysis** “… deals with the “here and now” of situations … It looks for strengths that could be activated and brought to bear on the existential situation. While acknowledging present difficulties, it looks to the future with hope, trusting that inner resources are available which can be tapped.” (Graber, 2004, p. 39). “Although the personal background is essential to understand the patient, existential analysis is… oriented … to the future: to capacities a person still has, or can have for realising meaning.” (Mendez, 2004, p. 61). **Existential Analysis** pertains more to the *assessment* phase, whereas the term Logotherapy applies to meaning-centred *treatment* (Graber, 2004).

**Evidence-Base:** As this assessment is very much focused on man’s **Values** and **Responsibility**, please see evidence under these headings.

**Example:** **Existential Analysis** of a client with post-natal Depression* and panic symptoms revealed that the situation’s meaning was related to what was nearest and dearest to her, i.e. to her main values, i.e. her baby and that it should receive the best possible care. The spiritual dimension in this situation was appealing to her defiant power of the human Spirit*, freeing herself of the debilitating panic and worries. “Why don’t you just sleep through and leave the baby crying?” the therapist asked. This enabled her to realise that her baby’s health and well-being is a most important value to her, for which sacrificing her sleep is a responsible act.

**Exercise:** Taking one of your clients’ or your own issues, explore its meaning, spiritual and responsibility dimensions, fitting it into an **Existential Analysis** grid:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Meaning/Value</th>
<th>(Defiant Power of the) Human Spirit</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. Challenge of coping with new baby</td>
<td>e.g. My baby’s welfare is paramount</td>
<td>e.g. I don’t have to put up with every one of my follies!</td>
<td>e.g. This value is even worth sacrificing my own sleep for if necessary.</td>
</tr>
</tbody>
</table>
Existential Issues:
Description: Questions about meaning of life and death are discussed under this heading.
Background: Logotherapy holds that Existential Issues are part of human nature and asking these types of questions regarding the meaning of life is not pathological. Rather, it is typically human to ask such questions. The therapist helps the client detect answers to these questions using Socratic Dialogue*. The clients may choose to consult other sources such as research, community/religious/spiritual/cultural etc leaders, peers, family, friends, work colleagues etc. However, only the client can make the decision which path he chooses to follow.
Evidence-Base: See Socratic Dialogue*.
Example: A very old person wanted to discuss with his peers how to make good choices for his remaining months or years, was unable to explore this issue with them as they avoided it saying he should not be so “morbid” (Ingram, 2006, p. 230). A therapeutic encounter can help in such a situation if the therapist is willing to take such issues on board. The therapist may use Doherty’s moral responsibility framework for therapists:
“1. Validate the language of moral concern when clients use it spontaneously.
2. Introduce language to make more explicit the moral horizon of the client’s concerns.
3. Ask questions about the client’s perceptions of the consequences of actions on others, and explore the personal, familial, religious, and cultural sources of these moral sensibilities.
4. Articulate the moral dilemma without giving your position.
5. Bring research knowledge and clinical insight to bear on the consequences of certain actions, particularly for vulnerable individuals.
6. Describe how you generally see the issue and how you tend to weigh the moral opinions, emphasizing that every situation is unique and that the client will, of course, make his or her own decision.
7. Say directly how concerned you are about the moral consequences of the client’s actions.
8. Clearly state when you cannot support a client’s decision or behaviour, explaining your decision on moral grounds and, if necessary, withdraw from the case.” (Ingram, 2006, 282)
Exercise: Try out using the above framework in role play. What do you notice? In what kind of situations might this framework be helpful? Would you amend it any way, and if so how?

Existential Vacuum:
Description: A lack of Meaning* leads to the feeling that one is devoid of Purpose in Life*. Such a vacuum can develop in people who are outwardly exceedingly successful; they may experience the success as shallow or hollow, indicating that their true Values* need unearthing and subsequent expression (see example below).
Background: This develops from an initial existential crisis, where people ask themselves what their meaning in life is, and they seem unable to find an answer. The fact, that they ask this question, is healthy, and this initial not knowing is not pathological (Frankl, 1985): “A man’s concern, even his despair, over the worthwhileness of his life is an existential distress but by no means a mental disease”. (Frankl, 1985, p. 125). People who view the world in terms ‘having’ rather than ‘being’ are more likely to experience an Existential Vacuum, as it is concerned with superficial aspects, whereas ‘being’ deals with essential core aspects of human beings and the situations they find themselves in (see Frankl, 1996; see also Fromm, 1997). The job of the clinician is then to help the clients grow in this situation by supporting them towards self-
detachment and self-transcendence. Sometimes, it is also necessary to lead them back to the small jobs and joys of each moment in life, as the ultimate meaning might not always be visible (Fabry, 1969).

Logotherapy’s aim is to treat human beings in a holistic approach (Frankl, 1996), and Socratic dialogue* is one of the instruments that help the practitioner achieve this goal. (see Fabry, 2004).

Evidence-Base: Barker, Pistrang & Elliot (2002, p. 3) caution that first-time researchers “may experience considerable anxiety—rather like the existential anxiety that accompanies a loss of meaning”. See also evidence under Socratic dialogue*.

Example: “Meredith... suffered from high blood pressure and panic attacks... her anxiety began with the birth of her first and only child. Meredith was seen... elaborating and clarifying the way in which she related to the world generally... What began as a referral for panic became a... re-examination of the values by which she lived. Discussing her difficulty in relating to some of the irreversible givens of human existence allowed her to take the opportunity to make changes in her relationships with people, her occupational direction, and her understanding of the world.” (Bretherton & Ørdner, 2004, pp. 423-424).

Exercise: As PPD: “Recall a situation in your work life in which you were challenged to examine your commitment to meaningful values or goals (this may even be your situation today). Perhaps you were faced with a job assignment that wasn’t in alignment with your personal values. Perhaps you were just unhappy with the work that you were doing. How did you first come to recognize this challenge? What, if anything, did you actually do about it? As you think about the situation now, what did you learn from it? In particular, what did you learn about your commitment to meaningful values and goals...? In hindsight, what would you have done differently in this situation...? How do you ensure that you remain committed to meaningful values and goals...?” (Pattakos, 2004, pp. 76-77).

Experiencing something/-one:
Description: This is in Logotherapy the second way of finding meaning (besides creative and attitudinal Values*). It is meant to show that besides creating something or doing a deed as well as changing oneself and one’s attitudes, the receptive, reflective mode of living is helpful in gathering strength and giving purpose.

Background: Logotherapy advocates using carefully chosen literature, art, music, films etc. in therapy, thus enhancing the range of experiences clients encounter. Each of these have a certain message, which helps the client understand a concept and see it applied in a story or feel its impact in the magnificent harmonies of Beethoven’s 9th symphony. Re-telling the story of Tolstoy’s Ivan Ilich illustrated for the prison inmate/s that life has meaning until the last moment (see example for Response-ability/Responsible-ness*).

Evidence-Base: Chang (1996) shows with his cross-cultural research that especially in Asian communities, the importance of Experiencing something/-one may be much more fully understood.

Example: Clients may find that it was worth living considering a vital encounter they were fortunate to experience (see e.g. Chan, 2008). Such an encounter can even happen at work: “In 1995, when fire destroyed the Malden Mills factory in Massachusetts, 3,000 people were instantly out of jobs. But not for long. As he watched his factory burn, Aaron Feuerstein, president and CEO of the company, decided then and there that it was not the end of Malden Mills. The first thing he did was keep all 3,000 workers on the payroll with full benefits for three months. There was nowhere for them to work, but in his heart, mind, and soul he knew that it
was unconscionable to put 3,000 people out on the streets... It cost millions of dollars to keep all 3,000 workers on the payroll and put the company into bankruptcy, but Feuerstein prevailed. He risked everything – his money, his reputation, his business. He believed in his employees and they, in return, believed in him. He set up temporary plants in old warehouses and the collective response was astounding.

“Before the fire the plant produced 130,000 yards a week”, said Feuerstein. “A few weeks after the fire, it was up to 230,000 yards. Our people became very creative. They were willing to work 25 hours a week.”... The employees ... committed themselves to the collective good. In 2003, the company came out of bankruptcy.” (Pattakos, 2004, pp. 74-75)

Exercise: Applying the lesson from the above example, explore different ways in which you can change your part of the world in a meaningful way. Note your observations and reflections in your Reflective Journal, possibly sharing some of your thoughts with a colleague. This may even inspire you to use these reflections in your therapeutic work.

Expressive Writing:
Description: Also called emotional writing, it is a technique whereby a person writes about their innermost thoughts and feelings, letting really go.

Background: This is an approach developed by Pennebaker (1997) when he had his own difficulties and found that writing about them helped him clarify his thinking and his feelings. He subsequently did many studies exploring this technique (for a summary see Pennebaker & Chung, in press).

Evidence-Base: Most reviews suggest Expressive Writing has a good evidence-base (e.g. King, 2002).

Example: Pennebaker (1997) married early. After a few years, he re-assessed his marriage and became despondent. “After about a month of emotional isolation, I started writing about my deepest thoughts and feelings. I remember being drawn to the typewriter each afternoon for about a week, where I would spend anywhere from 10 minutes to an hour pounding on the keys... Each day after writing, I felt fatigued, yet freer. For the first time in years – perhaps ever – I had a sense of meaning and direction. I fundamentally understood my deep love for my wife...” (Pennebaker, 1997, p. 30)

Exercise: Using Pennebaker’s (1997) paradigm, write about thoughts and feelings about something important to you on four consecutive days for 20 minutes each. Let yourself go, not worrying about grammar or spelling.

Fate-Freedom Balance
Description: Every fate has its parallel freedom (see exercise below). Thus, the therapist’s task is to support clients in discovering the degrees of freedom open to them as well as enabling them to pursue these windows of opportunity in a meaningful way.

Background: Logotherapy* asserts - within the obvious boundaries and limitations human beings find themselves in – a degree of free will that each and every Person* can utilise. Without this assumption, attending psychological treatment sessions would be futile. In addition, “The decision of today is the drive of tomorrow” (Frankl, 1996, p. 143; translation by the first author), which means that by utilising one’s degrees of freedom, the Person* increases the likelihood of acting similarly in the future. At the same time, the individual is free to change according to the motto that one does not have to put up with one’s own nonsense (Frankl, 1996). Clinicians need to use their freedom for the benefit of their clients/patients by seeing them in a
humanistic, dignified manner, remembering to treat them as a **Person** rather than as an ‘it’ (see Johnstone, 2000).

**Evidence-Base:** Human potential is exemplified in Positive Psychology research (e.g. Boniwell, 2006; Carr, 2004; Linley & Joseph, 2004). It shows what human beings are able to achieve when making optimal use of their degrees of freedom, e.g. in the areas of applying **Exercise** and **Expressive Writing** in order to improve one’s health (e.g. Pennebaker & Chung, in press).

**Example:**

Rebecca, due to a severe hip injury, had to be confined to a wheelchair, which severely restricted her ability to move around, travel, and generally live her active life. Not to be dismayed, she remained positive about her plight; she visualized a redesigned work situation for herself and took action to bring it about – all at the age of 89 years young! Rebecca still consults with individuals and organizations, but with a renewed focus on disabled workers. More than simply positive thinking, hers is a case of true optimism. She exercised her freedom to choose her attitude under difficult circumstances and expanded her life creatively in yet a new way.

We all have this ultimate freedom but, again, each of us must make an active choice to exercise it. The first questions to ask yourself when facing a challenging situation are: Are you aware of your current attitude toward the situation? Are you willing to change it? (Pattakos, 2004, pp. 48-49)

**Exercise:** “Whenever we speak of freedom, such as Freedom of Will, one is reminded of fate. What is ‘freedom,’ and what is ‘fate?’ On a sheet of paper, make two columns: One stands for ‘Fate’ – all those events which we cannot change. The other column stands for ‘Freedom’ – what is in our ‘hands’ to change? List all the points that come to your mind under both columns. The columns will now give you a sense of your respective areas of personal freedom, and fate.” (Mendez, 2004, p. 41) - Describe your clients from the vantage point of an admirer, discerning the small junctions where they have chosen to have a positive impact on their world including on their own selves. How can we encourage more of these choices of freedom?

**Flow:**

**Description:** Tasks which are intrinsically interesting to the person and require skill, posing a challenge, may catapult the person into being completely immersed in and absorbed by the task at hand, i.e. being in **Flow** (Nakamura & Csikszentmihalyi, 2005).

**Background:** **Flow** can be conceptualised in the following model:

Evidence-Base: Persistence at the task at hand due to the rewards of experiencing the Flow state has been found in studies (for a summary see Nakamura & Csikszentmihalyi, 2005).

Example: Having internalised Flow’s credo: Don’t hope to get money, or honour or a pat on the back, expect nothing. Do it because you enjoy doing it! , the first author set out to write this book. Spending time on it was a reward for less enjoyable tasks such as administrative duties and attending meetings.

Exercise: Reread Flow’s credo in the example above. Ask yourself (as PPD) and/or your client (as part of strengths-based intervention): What enjoyable activities bring you into a state of immersion to the point of (almost) forgetting time and place? How often do you do them? In what way can you incorporate them even more into your day to day life in a beneficial way?

Forgiveness:
Description: This is the idea of letting-go of a real or perceived hurt/damage caused by another.
Background: Forgiveness is a concept closely related to Guilt*. Once Guilt* is acknowledged and repair is attempted, the other person/s can forgive the perpetrator and move beyond the event. Enright (2001) has taken this idea a step further in his four phase Forgiveness programme, where he advises to detect one’s anger, choosing to forgive, develop Forgiveness, and emerge stronger by letting go of unhelpful emotions (Enright, 2001). The questions that clients need to ask themselves in each phase are:

1. “Uncovering Your Anger (How have you avoided dealing with anger? Have you faced
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your anger? Are you afraid to expose your shame or guilt? Has your anger affected your health? Have you been obsessed about the injury or the offender? Do you compare your situation with that of the offender? Has the injury caused a permanent change in your life? Has the injury changed your worldview?

2. Deciding to Forgive (Decide that what you have been doing hasn’t worked. Be willing to begin the forgiveness process. Decide to forgive.)

3. Work on forgiveness (Work towards understanding. Work towards compassion. Accept the pain. Give the offender a gift.)


Evidence-Base: Enright & Fitzgibbons (2005) report about five studies which support this Forgiveness work. In addition, Wohl, Pychyl, & Bennett (2010) found that self-Forgiveness helped students overcome procrastination by acknowledging the wrong done and forgiving it, thus freeing themselves of the emotional burden and allowing a fresh start.

Example: “Mary Ann, a 38-year-old mother of three children who suffered a turbulent marriage, sat in a tiny office staring across the desk at the unsmiling counsellor... She wanted to vent her frustrations about her mother. At the same time, she was trying to save her marriage, protect her children, and drag herself out of a hole of despondency. She had expected comfort and consolation, which she received, but Mary Ann was not ready for this question near the session’s end: “Have you considered the possibility of forgiving your mother?” Dr. Malaki ended with, “It’s your decision. Let’s meet again next week.” Four weeks and four sessions followed... In the fifth session, without feeling or conviction, through clenched teeth, and as a simple act of the will, she said to the counsellor, “I forgive my mother.” With that began a journey into freedom.” (Enright, 2001, pp. 3-4).

Exercise: Think of a person who you need to forgive (it might even be yourself) and, using the above steps, work towards Forgiveness (see also the example for Obsessive-Compulsive Disorder).

Formulation:

Description: Case Formulation, also called case conceptualisation, is the attempt to develop an understanding of the situation they find themselves in. It combines the findings of the individual case with the theory or theories that underpin/s it, thus furthering theory-practice integration and Meaning discovery.

Background: There are numerous ways of formulating, which is helpful as “You must create a formulation that fits the client rather than try to squeeze the client into your preferred formulation” (Ingram, 2006, p. xx). A widely accepted and used framework for case conceptualisations is based on five factors: Predisposing, Precipitating (a.k.a. Triggers), Presenting, Perpetuating (a.k.a. Maintaining) and Protective factors (e.g., Kuyken, Padesky, & Dudley, 2009). These are then often sub-divided into person and context, thus forming a 5 x 2 cells table. Adding the logotherapeutic dimensions of physical, psychosocial and existential/meaning dimensions, we arrive at the following three-dimensional Formulation grid (Fabry, 2004):
Aspects

Context

Person

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Predisposing</th>
<th>Precipitating</th>
<th>Presenting</th>
<th>Perpetuating</th>
<th>Protective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existential/ Meaning</td>
<td></td>
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<tr>
<td>Psychosocial</td>
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<tr>
<td>Physical</td>
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</tbody>
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Factors

Figure 4: Three-dimensional **Formulation** grid (Fabry, 2004)

A more longitudinal formulation can be presented in the following diagram (see Fabry & Greenbaum, 2008), which is adapted from CBT literature (e.g. Greenberger & Padesky, 1995): The four-leaf clover formulation template.
Figure 5: The Four-Leaf Clover (Fabry & Greenbaum, 2008)
Use it to help clients understand how their learning history is the nurturing ground for their current Strengths* as well as challenges. Forgiveness* towards significant others as well as themselves will help in triumphing over their challenges and limitations. Reflecting the Fate-Freedom Balance*, this Formulation reflects that “The Choice is Yours” (award winning film about Logotherapy by Yorkin Drazen, 2001), i.e. clients chose their stance towards their circumstances, learning history etc. Using a balanced account of it highlighting achievements and Strengths* will help them make an informed choice. It can be adapted to reflect clients’ value systems and own analogies, e.g. by replacing the butterfly with symbolism more akin to the clients’ experiences.


He then moves on to the integrative “stages of change” model (Prochaska & DiClemente, 1992) derived from a meta-analysis of numerous outcome studies which showed that a variety of techniques lead to similar outcomes.

### Prochaska and DiClemente’s Stages of Change Model

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Characteristics</th>
<th>Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Not currently considering change: “Ignorance is bliss” Validate lack of readiness Clarify: decision is theirs Encourage re-evaluation of current behavior Encourage self-exploration, not action Explain and personalize the risk</td>
<td></td>
</tr>
<tr>
<td>Contemplation</td>
<td>Ambivalent about change: “Sitting on the fence” Not considering change within the next month Validate lack of readiness Clarify: decision is theirs Encourage evaluation of pros and cons of behavior change Identify and promote new, positive outcome expectations</td>
<td></td>
</tr>
<tr>
<td>Preparation</td>
<td>Some experience with change and are trying to change: “Testing the waters” Planning to act within 1 month Identify and assist in problem solving re: obstacles Help patient identify social support Verify that patient has underlying skills for behavior change Encourage small initial steps</td>
<td></td>
</tr>
</tbody>
</table>
Having carried out extensive research on change behaviour using their decisional balance questionnaire for assessing the pros and cons of change, Prochaska et al, 1994 found out that the balance of pros and cons must reach a certain balance in order for effective change to happen.

**Evidence-Base:** Prochaska & DiClemente’s (1992) trans-theoretical Stages of Change Model is based on evidence and has been cross-validated (Prochaska, 1999).

**Example:** The following example illustrates the above existential/meaning dimension:

A prominent attorney had to have his leg amputated for arteriosclerotic gangrene. When he left his bed for the first time after the operation to try to walk on one leg, he burst into tears. Whereupon his doctors asked him whether he hoped to run a four-minute mile – because only if that were his aim did he have any cause for despair. This question instantly conjured up a smile amidst the tears. The patient had promptly grasped the obvious fact that the meaning of life did not consist of walking jauntily – not even for a distance runner – and that human life is not so poor a thing that losing a limb would make it meaningless. (Comparisons ... may well be taken from the world of sports... patients can learn to be “good sports”; they can learn that difficulties only make life more meaningful, never meaningless. The typical athlete seeks and makes difficulties for himself – consider obstacle races or handicap races. The greater the handicap... the greater the honor... (Frankl, 1986, p. 282).

**Exercise:** Take your time to gather data. Remember: “Restrain yourself from intervening until you have a formulation to guide you.” (Ingram, 2006, p. 28). Now offer your client one or more of the above ways of making sense of their situation (see Formulation grids above). What happens? Does this increase their understanding of their situation in a helpful way? Does is link in with theory and evidence? Amendments and re-Formulation* are part of the process!
Functional Analysis:
Description: Being a term developed in Behaviour Therapy, Functional Analysis entails analysing how clients’ behaviours are evoked and perpetuated.
Background: “Behavioral research demonstrates that behaviors can be learned and extinguished on the basis of patterns of association, reward, and punishment. The following simple acronym distils functional analysis into a format that is readily accessible to clients and therapists in the early stages of conceptualising presenting issues:
A(antecedent)-B(behavior)-C(consequence)

Antecedents refer to the contexts associated with the onset of behaviors. These can be associations, conditions, or triggers for the behavior. Antecedents can be external to the behaviour (e.g., meetings at work) or internal (e.g., particular thoughts). For the purposes of case conceptualisation the behaviors highlighted in this model are typically “molar” or higher-order behaviors such as behavioural avoidance… It is important to note that in functional analysis, behavior can include cognitive processes such as worry. Consequences are typically direct rewards (e.g., praise) or secondary rewards that come from avoiding aversive experience (e.g., reduction in anxiety after avoiding a meeting).” (Kyuken, Padesky & Dudley, 2009, pp. 139-140)

Functional Analysis can be helpful in Positive Psychology, e.g. when looking at client’s Resilience* (see example below).

Evidence-Base: Systematic reviews on studies in autism highlight the effectiveness of this method (e.g. Howlin, Magiati & Charman, 2009).

Example: “…Mark described a day when his mood had been good. He described how he had not worried so much: ”I didn’t get caught up with negative thinking.” His behaviour resembled that of his colleague Peter, whom he regarded as effective at work. Mark’s therapist used the ABC model to conceptualise this example of Mark’s resilience in the face of thinking about mistakes at work… Positive examples identify success that Mark can link to a healthier view of himself. Understanding the positive consequences of resilient responses can encourage Mark to practice these more often in order to overcome his low mood.

Antecedents------→Behaviours------→Consequences
Thoughts about Mistakes at work. Manage my tasks more like I imagine Peter does: take credit Experience of mastery.
For good things that happen Feel good about myself.
And admit mistakes without Getting too caught up with them Feel like I am not such a mess.
Or putting off my work for fear Of making a mistake.
The example … was a particularly powerful learning experience for Mark because he started to worry that evening and his mood dropped again. Within the same day, Mark was able to observe the behaviors that maintained a positive mood and triggered a low mood. Highlighting this contrast creates dissonance and can motivate clients to learn and rehearse more resilient behaviors (McCullough, 2000).” ((Kyuken, Padesky & Dudley, 2009, pp. 180-181)

Exercise: Take one of your own behaviours such as avoidance, procrastination etc. Having created a Functional Analysis of this behaviour, please look for exceptions and re-analyse in terms of Resilience* (see Mark’s example above).
Goals:
Description: “Life goals, which are also called core goals, personal strivings, personal projects, life tasks, and future aspirations are specific motivational objectives by which we direct our lives.” (Boniwell, 2006, p. 53).
Background: In Logotherapy*, Goals are important to establish the future dimension in the therapeutic work. With Goals in mind, steps towards achieving them will help clients improve their knowledge and skills in various meaningful ways, occupy them with valuable activities and enhance their self-esteem (see Graber, 2004; Mendez, 2004).
Evidence-Base: Goal research suggests that setting and achieving Goals increases Happiness* and well-being (for a summary see Diener, Lucas & Oishi, 2005).
Example: Mrs X was happy with her therapy progress to the surprise of her therapist, and Mr Y was dissatisfied despite objective progress. The mismatch in both cases was caused by a lack of specific agreed upon Goals (see e.g. Espie, 1991). No wonder expectations were different and led to problems in the therapeutic relationship.
Exercise: “Goals can be in conflict with our values, which is what incongruence is about. However, goals can also be in conflict within themselves (e.g. when achievement of one goal blocks the achievement of another). You can establish a dialogue between conflicting goals to see if they can find a common ground.” (Boniwell, 2006, based on Diener & Fujita, 1995).

Gratitude:
Description: “When a person receives a gift or benefit, a typical emotional response is gratitude directed towards the source of the gift.” (Bono, Emmons & McCullough, 2004, p. 464).
Background: “The attitude of gratitude … is also a way of engendering attitudinal values, which help patients to grow and to gain strength and trust in facing obstacles.” (Mendez, 2004, p. 137). Gratitude has been emphasised by the various faiths and ethical thinkers. The Thanksgiving Leadership Forum of Dallas gives scholarships to winners of their Gratitude essay writing contests (Peterson & Seligman, 2005).
Several measures of Gratitude such as McCullough, Emmons & Tsang’s (2002) Gratitude Questionnaire and Gratitude adjective list exist.
Evidence-Base: There is growing evidence for the benefits of Gratitude, such as interpersonal, psychological, biological (health, longevity etc.) and spiritual (for a summary see Wood et al., 2010 and Peterson & Seligman, 2005).
Example: “The British writer G. H. Chesterton might be the prototype... delighted in the ordinary, was surprised and awed by his own existence and the existence of all else. He set for himself the conscious goal of remaining childlike in his sense of wonder and vowed not to succumb to the monotony and boredom that sap so many lives of joy and purpose... ‘I like the Cyclostyle ink, it is so inky. I do not think there is anyone who takes quite such fierce pleasure in things being themselves as I do. The startling wetness of water excites and intoxicates me...the test of all happiness is gratitude...We thank people for birthday presents...Can I thank no one for the birthday present of birth?’...One is never lacking in opportunities to be happy, according to Chesterton, because around every corner is another gift waiting to surprise us, and it will surprise us, if we can achieve control over our natural tendencies to make comparisons, to take things for granted, and to feel entitled.” (Peterson & Seligman, 2005, p. 554)
Exercise: Try asking clients what they are grateful, and use this a tool of assessment and evaluation in the therapeutic process. What do you notice? See also the Counting One’s Blessings* exercise!
Guilt:

Description: Guilt is the feeling of having done something wrong, which is a human phenomenon each human being has to face (Frankl, 1985; Kalmar, 1997). It is part of the symptoms of Depression* as well as of the Tragic Triad*. 

Background: Frankl (1985) described pain, Guilt and death as the three concerns forming the Tragic Triad*. Stemming from conscience, which is man’s meaning organ (Frankl, 1985), it is their in-built mechanism which helps them correct their ways and make amends. Through acknowledging Guilt and its origin, clients acknowledge their responsibility as well as ability to respond (Responsibleness*). Once this has happened, they can make restoration for any harm caused and start fresh. Forgiveness* including self-Forgiveness* play a part in this process. In Depression*, Socratic Dialogue* can help explore how many degrees of freedom the client realistically had in any given situation (see example below).

Evidence-Base: See evidence-base for Forgiveness*.

Example: Greenberger & Padesky (1995) describe Vic, who felt guilty towards his wife for shouting at her. He completes a responsibility pie, in which he recognises other factors such as late time of day, debts and his wife bringing up a problem when he was tired. Nevertheless, he acknowledges that he is mainly responsible for his outburst. He then decides to make amends thus “deriving from guilt the opportunity to change oneself for the better” (Frankl, 1985, p. 162).

Exercise: Taking the following steps from Greenberger & Padesky, (1995), work through one of your own Guilt feelings:

- Describe the situation.
- List all factors that led to the outcome.
- Draw a pie chart and divide it into sections proportionate to the perceived contribution this person, factor, situation etc. had towards the negative event/situation that caused the Guilt feelings.
- Other steps are self-forgiveness (see Forgiveness*) and making reparations (Greenberger & Padesky, 1995). Reflect on the process, then help your clients with added insight and empathy which you have gained through your self-practice and self-reflection (see Bennett-Levy, 2006).

Happiness:

Description: Happiness, a.k.a. eudemonia, positive affect, positive emotion, well-being etc., is one of the main areas of Positive Psychology work.

Background: Logotherapy holds that “Normally, pleasure is never the goal of human strivings but rather … the side effect of attaining a goal” (Frankl, 1988, p. 34). “The very pursuit of happiness thwarts it” (Frankl, 1988, p. 33). On the other hand, Positive Psychology has developed exercises to increase Happiness such as Counting One’s Blessings*. How can this apparent discrepancy make sense? As Boniwell (2006) holds, finding positive meaning, reframing and finding value can help bridge the gap between them (see Exercise below).

Evidence-Base: The evidence suggests that “positive affect and well-being lead to sociability, better health, success, self-regulation and helping behaviour… enhances creativity and divergent thinking … happy people persist longer at a task that is not enjoyable in itself…, are better at
multi-tasking and are more systematic and attentive… well-being is associated with longevity” (Boniwell, 2006, p. 31).

Example: Sister Selma quotes a poem that contains her formula for **Happiness**/joy (for her life story see **Kindness**):

I slept and I dreamt that life was joy.
I awoke and I saw that life was duty.
I acted and beheld that duty was joy. (Olomeinu, 1974, p. 3)

Exercise: “We can’t simply will ourselves to feel a particular emotion, nor can anyone instil it in us. Even engaging in pleasant activities does not guarantee positive emotion, because they depend on our interpretations. What we can do is make an effort to find positive meaning in our daily activities by reframing them in positive terms or discovering a positive value in these activities” (Boniwell, 2006, p. 11; see also Frankl, 1999; Linehan, 1997b). Engage in reframing and value detection of one of your recent challenges. Does this lead to **Happiness**?

**Hope:**

Description: **Hope** is a central aspect of therapy as well as general well-being. It is one of the character strengths in the CSV (Peterson & Seligman, 2004).

Background: The conceptualisation of **Hope** can be divided into two categories: emotion-based and/or cognition based. There is considerable overlap between the two categories, where affect and cognition are linked (Lopez et al., 2003).

**Hope** as an emotion or affect is postulated as environmentally dependent, where **Hope** is achieved when goals are 1) reasonably possible, 2) under control, 3) viewed as important to the individual and 4) within social and moralistic norms (Averill, et al., 1990). This definition of **Hope** is based on a social-constructionist approach. **Hope** may also be conceptualised within a behavioural standpoint, whereby perceived pleasurable outcomes can illicit the emotion of **Hope** (Mowrer, 1960).

**Hope** is also conceptualised as a coping mechanism in seemingly hopeless contexts (Godfrey, 1987).

Cognitively, **Hope** is seen as a natural and healthy part of cognitive development, a belief that continually propels us toward our goals, desires and aspirations and away from unfavourable outcomes (Erikson, 1964). These goals can, however, also conflict with those of others, thus requiring negotiation to take place.

Breznitz (1986) states that **Hope** relates to cognitions which can produce physiological changes. Other theorists suggest that **Hope** can only be produced when an organism is able to determine the probability of attaining a goal, gives it a sufficiently high level of importance and is optimistic in achieving it.

Barriers to **Hope** bring stress to an organism, leading to appraising the current route towards success, and altering the path accordingly with negative and positive emotions as negative and positive feedback to the organism.

Synder et al (2000) suggest that individuals termed as ‘high-hopers’ tend to have more positive emotions, are motivated and have a zest for life. Conversely, low-hopers tend to have histories of being unable to deal with stressors, showing flat affect, and are negatively trait laden.

In their **Hope** theory, Lopez et al. (2003) integrate both emotional and cognitive aspects.

Evidence-Base:

The **Hope** construct has been the subject of quite a number of research projects, utilising instruments such as:
The Hope Scale (Erickson, Post & Paige, 1975) with sound psychometric properties of its two subscales: Importance (I) and Probability (P).

Staats’ two scales measuring the affective (Expected Balance Scale, EBS) and the cognitive aspect (Hope Index; Staats, 1989).

Snyder’s Hope Scales (see Nassar, 2008a for a review) encompassing the two factor model of ‘pathways’ (the ability to find routes to desired goals and outcomes) and ‘agency’ (the motivation to use said routes) (Synder et al., 2007). Two scales for adults (measuring traits and states) and one for children, both with sound psychometric properties, have been developed.

The following correlates of Hope have been found:

- Positive correlations with positive coping styles and negative ones with negative coping styles (Chen et al., 2009).
- Synder et al (1991) found that Hope scores correlate positively (r=0.50 – 0.60) with measures for Optimism*, expectancy for attaining goals and self esteem.
- Hope has also been correlated with higher tolerance to pain (Berg et al., 2008).
- Lloyd et al (2009) reports a significant correlation between hope and adherence to medical regimen and glycemic control in adolescents with type one diabetes. Lloyd also found that hope is associated with perceived maternal empathy.
- Similar relationships have been noted in academic attainment, personal adjustment, and global life satisfaction (Gilman et al., 2006; Sears, 2007), emphasising the need for Hope enhancing interventions for children and adolescents with diminished Hope in academic settings.

In addition, increased Hope led to success of trauma bereavement programmes (Buchanan et al., 1996). In another study, higher Hope scores predicted greater well-being and the ability to find meaning (Michael et al., 2005).

Investigating individuals adjusting to old age, Hope (pathways) predicted all factors of adaptation (Maraitou et al., 2006). Ennis (2007) found that those with higher Hope scores perceived less barriers to attainment and greater family functioning.

Kraatz et al (2004) studied outcomes of a mental health clinic providing short term psychotherapy targeting depression and psychological distress with emphasis placed upon increasing Hope. They found an inverse relationship between pre-treatment distress and depression and post-treatment Hope scores.

**Example:** Frankl (1985) describes in his pivotal work Man’s Search for Meaning the immense effect giving up Hope can have:

> I once had a dramatic demonstration of the close link between the loss of faith in the future and this dangerous giving up. F--- ... confided in me one day: “...I have had a strange dream. A voice told me that I could wish for something, ... and all my questions would be answered. ... I wanted to know when we ... would be liberated...” “What did your dream voice answer?”... “March thirtieth.”

> When F--- told me about this dream, he was still full of hope... But as the promised day drew nearer, the war news which reached our camp made it appear very unlikely that we would be free on the promised day. On March twenty-ninth, F--- suddenly became ill and ran a high temperature... On March thirty-first, he was dead. To all outward appearances, he had died of typhus.

> Those who know how close the connection is between the state of mind of a man – his courage and hope, or lack of them – and the state of immunity of his body will understand that the sudden loss of hope and courage can have a deathly effect. (Frankl, 1985, p. 96-97).
Boniwell (2006) gives an account of her feelings of Hope despite all odds: “I am writing this chapter in Central London on the 7th July 2005, stopping frequently to catch the latest news about the four explosions and responding to multiple phone calls from family and friends, checking if we are OK. In the midst of this nightmare, with images of buses without their tops and reports on people still stuck in the underground, I am not optimistic about the future. Having learnt from the post September 11th trajectory, I can see the rise in the psychology of fear on English soil, antiterrorist measures dominating the media, and the celebrated multiculturalism of London descending into hatred and suspicion towards the Muslim population. Yet I am hopeful. Hopeful that everything will be alright in the end, despite the fact that I do not know what this ‘alright’ may look like, how we can get there, and whether I personally can do anything about it. Exercise: “In order to generate hope, first formulate your goals, think of several ways of how these can be achieved and select the best one, break your goals into smaller sub-goals, motivate yourself to pursue your goals and reframe any obstacles you meet as challenges to be overcome” (Boniwell, 2006, p. 23; See also Snyder, Rand, Sigmon, 2005)

Humility/Modesty:
Description: Humility “involves a nondefensive willingness to see the self accurately, including both strengths and weaknesses” (Peterson & Seligman, 2004, p. 463). Modesty is “the moderate estimation of one’s merits or achievements and also extends into other issues relating to propriety in dress and social behaviour.” (Peterson & Seligman, 2004, p. 463)
Background: “For humble people, there should be no press toward self-importance and no burning need to see – or present – themselves as better than they actually are… not be particularly interested in dominating others … On the other hand, humility should not lead people to take harsh or condemning approaches towards themselves…” (Peterson & Seligman, 2004, pp. 463-464). Humility also I includes seeing oneself from a larger perspective (Peterson & Seligman, 2004).
Evidence-Base: Evidence on the opposite of Humility, i.e. narcissism (see DSM IV), has found low social anxiety and high self-esteem (although this may fluctuate) coupled with high aggressiveness in those with an inflated ego and feelings of entitlement (see Peterson & Seligman, 2004). People with this mind set may have to use up much energy to maintain their overestimated self-evaluation. Thus, people who are humble are healthier as they are not concerned with the views of others and give freely of themselves.
Example: Frankl described himself as a midget, who stands on the shoulders of giants, i.e. the founders of Psychoanalysis (Freud) and Individual Therapy (Adler), respectively. This midget can see more as well as further ahead than the giants, but remains grateful, acknowledging the enormous contribution of others and downplaying one’s own achievements (Lukas, 2005).
Exercise: Reflect on the following suggestions by Peterson & Seligman (2004, p. 474): “…any technique, resource, or relationship that would provide a person with alternate means of feeling safe – besides their own self-evaluation – would facilitate humility. A sense of safety could come from religion, from secure attachments to parents or close others, or from significant others who communicate unconditional positive regard... It might also prove helpful for people to observe role models who are able and willing to accept both positive and negative information about themselves without overreacting. Regardless of the means used, the goal would be to enable the individual to feel safe enough to nondefensively acknowledge both strengths and limitations”. When have you felt safe enough to be open and honest about your strengths and weaknesses? What can you do to enhance your provision of a safe space for your clients’ honest self-
explore and reflection? Share your thoughts/entries in your Reflective Journal with your colleagues, supervisors and significant others. Make a plan to implement one point from this exercise which will help you (as a role model) and your clients become more humble and modest.

**Humour:**

**Description:** Carr (2004) describes Humour as a highly adaptive defence mechanism, “reframing the situation which gives rise to conflict or stress in an ironic or amusing way” (Carr, 2004, p. 232).

**Background:** In Logotherapy (e.g. Mendez, 2004), Humour is seen as a creative Value*. It expresses the **Defiant Power of the Human Spirit***, this strength of the human being to take a stance. Humour is particularly important in **Paradoxical Intention***, the technique which helps overcome one’s fears. Guttmann (1998) shows the benefit in incorporating Humour in the therapeutic encounter. Used in an amicable way, it promotes the working alliance, helps alleviate fears of judgement and rejection, helps clients develop a new model of social interaction and makes the therapy process more enjoyable (Carr, 2004). Good teachers try and make their students laugh in order to help them relax so they can better take the new information on board – and as therapists are teaching their clients, they are well advised in incorporating some laughter in session. This also corresponds to adaptive defences, which “Reduce anxiety by transforming impulse and anxiety into positive action” (Carr, 2004, p. 236). Laughter therapy and medical clowning are yet other examples of using Humour to help patients recover.

**Evidence-Base:** Strean (2009) reports on evidence in a variety of settings from geriatrics to terminal care (see also Miller, 2009).

**Example:** “A 95-year-old man, who was suffering from severe depression, was admitted to hospital. For several days, he had neither eaten nor spoken a single word. The doctors were concerned as they feared he might die very soon. Then a clown stepped into the patient’s room, and after half an hour, he had motivated the patient so much, that he spoke, laughed and ate again. This man carried on living for several years, and the clown kept in touch with him.” (Goerl, 1994, p. 65; translation by the author).

Another example concerns fear of flying. “A middle-aged woman was sitting in the plane next to me at the window. As soon as the pilot announced that the plane was ready to take off, she turned to me and asked in a trembling voice whether I would agree to change places with her. After the exchange of seats was completed and the plane began to gather speed she turned white and asked whether she could hold on to my hand. She seemed close to fainting. Her fear of flying was so obvious that there was no point in trying to reassure her that “everything will be O.K.” Spontaneously, I told her to squeeze my hand so hard until all the bones of my fingers would break, whereupon the woman burst into laughter, let go of my hand, smiled, and said that this was the first time in many years that she felt the flight would not cause her anguish. Furthermore she said, that from now on every time she has to fly and the fear reappears she will say to herself: ”Let’s break his bones.” The laughter that would inevitably follow would be sufficient to bring about the desired relaxation.” (Guttmann, 1998, pp. 18-19).

**Exercise:** Find a person whose hand you can hold every time you get anxiously aroused. Squeeze them really tightly to see how many bones you can break! Reflect on this exercise in your Reflective Journal.
Hyperreflection:
Description: Focusing excessively on difficulties (also called rumination).
Background: This tendency to worry can lead to despondency and depression (Frankl, 1985). Treatment using Dereflection* and/or Paradoxical Intention* can help the client overcome excessive self-observation via focusing on Values* or trying to increase worrying even further to a point, where it becomes impossible and thus funny. Forgiveness* as a way of overcoming rumination has also been found helpful (Brown & Phillips, 2005).
Evidence-Base: Rumination has been found to increase levels of Depression* as well as Anxiety* (e.g. Nolen-Hoeksma, 2000), thus showing the importance of addressing this tendency in therapy.
Example: “…in all his speaking and thinking, the patient used to observe himself so much, that he became anxious, that his obsession of observing himself might lead to him losing his train of thought during speaking. Anticipatory anxiety increased, which really handicapped his career. Within a few sessions [of paradoxical intention], the patient could be healed so far that he was e.g. able to give a free speech in front of a foreign envoy.” (Frankl, 1999, p. 174; translation and bracketed addition by the first author).
Exercise: Apply the above mentioned techniques to one of your own worries. What do you notice?

Insomnia:
Description: Sleep disturbance of some kind which burdens the person enough to visit a health professional.
Background: An involuntary process, sleep cannot be brought about by effort or intention. Thus, after careful medical assessment to exclude any underlying medical problem, Logotherapy advises to go against the urge to control the process and rather do the opposite: Stay awake!
Paradoxical Intention* takes the wind out of the sails of anticipatory anxiety which has thus far prevented the natural occurrence of sleep.
Evidence-Base: The SCP found strong evidence for Paradoxical Intention* (see also Fabry, 2010), CBT, Sleep Restriction Therapy, Stimulus Control Therapy, and Relaxation Training. Electromyograph (EMG) Biofeedback produced modest research evidence.
Example: In their Paradoxical Intention* study, Ascher & Efran (1978) instructed three clients to remain awake to examine the thoughts they had just before going to sleep more carefully. The remaining two clients were asked to lengthen a relaxation exercise, repeating some of the parts in order to more fully relax, thus instructing them to in effect lengthen the time-span before falling asleep. All of the clients failed their goals as they had fallen asleep instead.
Exercise: When you can’t fall asleep as well as – after careful medical and psychological check-up – with clients with sleep problems of an anticipatory nature (i.e. not nightmares or other causes), do the following exercise:
  - If you can’t get to sleep it might seem reasonable to ask someone who can how she manages it. Then surely all you have to do is follow her example. The problem is you always get the same answer, something like...
  - I just fall asleep…it just happens... (shrug of shoulders)... it’s easy. I just put the light out and close my eyes.
  - Not very helpful you think – but you would be wrong – the secret is right there. The good sleeper does precisely nothing to fall asleep.
Sleep is a natural process which happens involuntarily. The good sleeper doesn’t make it happen and neither can you. In fact, the harder you try the worse your... problem is likely to get; you just get more aware of not getting over to sleep and
probably more frustrated.

For the insomniac things get into a vicious cycle. Instead of looking forward to a bed as a time to relax and to enjoy ..., apprehension often develops as bedtime approaches. Unpleasant memories of hours spent lying awake or tossing and turning can come to mind and there is the prospect that the same thing might happen tonight. It can become like a self-fulfilling prophecy. You are so eager to fall asleep that you try too hard and all your efforts – turning this way and turning that way; thinking on these thoughts or on those thoughts – just seem to make you more alert. A fundamental problem is that your efforts to control the sleep process are part of the problem, not part of the solution. You actually snatch wakefulness out of the jaws of exhaustion. That really is frustrating!

Does this sound familiar? Well, I’m afraid there is nothing for it but to give up. Yes, that’s right you must give up trying to fall asleep. You are useless at it! Instead you should try to stay awake. That’s the only certain way for you to make sure that you stop interfering with your natural sleep. After all, if you are in your bed and it’s dark and you are really tired then you are not going to be able to stay awake for very long. Staying awake will probably get you to sleep more quickly because it stops you worrying and it stops you trying. What’s the point in worrying about still being awake when you’re trying to stay awake anyway? You are probably thinking, so I’ve to go ahead and be the worst insomniac I can be and just keep on staying awake. Then you would be quite right. A paradox, isn’t it? (Espie, 1991, p. 137).

Procedural instructions for patients following a paradoxical intention programme for insomnia
(1) When you go to bed lie down in a comfortable position and put the light out.
(2) In the darkened room try to keep your eyes open rather than closing them.
Each time they feel like closing tell yourself “it would be good to keep them open for another little while”.
(3) As time goes by congratulate yourself on your success at remaining awake. Remind yourself that it is comfortable in bed and that relaxing is good even if you’re not asleep.
(4) If you feel worried or irritable at not sleeping remind yourself “the plan is to remain awake so I’m doing fine”.
(5) Try to stay awake for as long as you can.
(6) Do not, however, use active methods to stay awake such as reading or physical movement. The idea is to resist sleep-onset gently but persistently.” (Espie, 1991, p. 139).

Kindness:
Description: People who tend to think of others’ needs rather than their own, and act on it in a gentle way are said to be kind. Kindness is one of the twenty-four character strengths described in the CSV (Peterson & Seligman, 2004).
Background: Kindness does not only create benefit for the recipient, it is also good for the people themselves, e.g. through lower levels of depression (Musick & Wilson, 2003). Thus, the assessment of this aspect of clients’ functioning is an important part in the overall intake interview.
Evidence-Base: Musick & Wilson’s (2003) study shows that Kindness is an important aspect in human functioning.
Example: Schwester Selma – Ninety Years of Joy
One of the most beloved citizens of Jerusalem became ninety years old this year... the first nurse in Israel... aided by a cane, she still walks the wards of Shaare Zedek hospital talking to patients... She... decided as a little girl that she would become a nurse. Why? She says, “Because my mother died when I was just five, and I decided to give others what I had missed so much—mother-love and concern for human beings.”...she founded the Shaare Zedek School of Nursing and led it for twenty years. She trained her girls in all the skills that a nurse has to know, but, most of all, Schwester Selma showed them how to put the needs of a patient ahead of everything else... During the polio epidemic of 1950-51, most nurses were afraid to expose themselves to the crippling contagious disease... Schwester Selma was never afraid. She was almost seventy, but she was always with us and she operated the iron lung that kept us alive. Few nurses have the common sense and loving concern that made her a great nurse.”(Olomeinu, 1974, p. 3); see also example under Happiness*.

Exercise: Use the following example questions to test yourself:

- “Others are just as important as me.
- All human beings are of equal worth.
- Having a warm and generous affect seems to bring reassurance and joy to others.
- Giving is more important than receiving.
- Doing good for others with love and kindness is the best way to live.
- I care for the ungrateful as well (as) the grateful.
- I am not the center of the universe but part of a common humanity.
- People who are suffering need compassion.
- People in need require care.
- It is important to help everyone, not just family and friends.” (Peterson & Seligman, 2004, p. 326).

Laws of Dimensional Ontology:

Description: Frankl (1996) developed two Laws of Dimensional Ontology to show:

a) Apparent contradictions in client’s presentations may be resolved by including a higher dimension in one’s Assessment*, i.e. the specifically human or meaning dimension; and

b) The same presentation can be due to a variety of different causes.

In these laws, Frankl uses geometrical analogies for human phenomena.

Background:

1. The first Law of Dimensional Ontology is: “One object, which is projected out of its dimension into different, lower dimensions, creates images, which contradict each other” (Frankl, 1996, p. 125-translation by the first author; see example below).
The somatic dimension (e.g., medical model) and psychosocial dimension (e.g., psychosocial models) may seemingly contradict each other, such as in the blind and deaf-mute Helen Keller, who studied languages at college. However, these apparent contradictions become meaningful when looking at the specifically human meaning-dimension: Her teacher A. S. Macy believed in her almost unlimited potential and treated her accordingly, thus enabling her to reach her potential. This is also reflected in Frankl’s often quoted Goethe citation that “if we take man as he is, we make him worse. But if we take man as he should be, we make him capable of becoming what he can be” (Frankl, 2010).

2. The second Law of Dimensional Ontology is: “Different objects, which are projected into a lower dimension, create images, which are ambiguous” (Frankl, 1996, p. 125—translation by the first author; see example below).
Why did Frankl develop these laws? He was careful to see the individual behind the presenting symptoms, thus teaching that very careful individual Assessment* and Formulation* are vital for successful treatment.

Evidence-Base: The first Law of Dimensional Ontology addresses the area of pathoplasticity, i.e. the fact that pathology can be displayed differently depending on e.g. cultural, personality or interpersonal factors (see e.g. studies by Stompe, Karakula, Rudaleviciene, Okribelashvili, Chaudhry, Idemudia, & Gscheider, 2006; Wright, Pincus, Conroy & Elliot, 2009; Hopwood, Clarke, & Perez, 2007).

The second Law of Dimensional Ontology makes a case for careful individual Formulation* as the same presentation may be caused by very different causes – for the evidence see Formulation*.

Example: Any given biological (e.g. dementia) or psych-social origin of an illness (e.g. deprivation or abuse) is only a framework within which the individual is free to respond, using their degrees of freedom in the human-spiritual realm, i.e. the third dimension in the diagram above also known as pathoplasticity. Thus, clients with dementia can respond with grace, using humour and art such as music (e.g. singing) to express themselves, thereby living life to the full under the given circumstances, enjoying a high subjective quality of life and endearing themselves to all they meet. Deprivation (and even abuse) can lead to giving to others that which the person lacked in their own upbringing (see example for Kindness* above).

Frankl’s example for the second Law of Dimensional Ontology is the writer Dostoyevsky who suffered from epilepsy, yet by only seeing his physiological condition and its psychosocial sequel instead of the whole human being in a holistic approach, the clinician misses out on vital areas (Frankl, 1996).

Exercise: Make an effort to come to know the whole human being you encounter in therapy, paying careful attention to their Strengths* and achievements.

Logoanchor:

Description: Using relaxation techniques, you try and find a memory or a future possibility where all was/will be well, happy, and one with the world. Visiting it regularly helps to nurture and sustain you in troubled times.

Background: “Inspired by Viktor Frankl’s experience of shifting focus in an intolerable situation to a desirable possibility … that some day he might be able to give a lecture on his life work. … I often employ what I think of as the logoanchor: An experience, rich in meaning, either from the past, or an anticipated one from the future (á la Frankl), which can be used as an anchor in a currently troubling situation” (Graber, 2004, pp. 155-156). How do you do it?

A preparatory explanation of the technique needs to be given so the client can decide if the closed eye process appeals to him. Where this is not the case, we search for logoanchors by recalling times of greater attunement to one’s core or center from memory.”... brief relaxation “Now let your consciousness drift, the way you do when you daydream. Let us go down memory lane in search of an experience that filled you with awe and wonder; a time when you felt most integrated and vitally alive! Look for a time when you were in touch with your uniqueness, your humanness in an essential way. … Bring that state of awareness forward to the present moment and cherish it…. See the memory clearly before you. Hear the sounds that accompanied the experience again. What tastes were
involved? Was it sweet, sour, bitter, salty, spicy? Notice the smells, odors, aromas or fragrances that accompanied the experience. What was it like to touch? What emotions were evoked? Put as many of these sensory impressions as you can together now into a holographic image and fully re-experience that moment again that was very life-giving… knowing that it is still alive within you and that you can use it again and again as a logoanchor whenever you are in need of one. (Graber, 2004, pp. 156-158).

Evidence-Base: **Logoanchor** is a form of hypnosis/age regression, a well-researched technique with good evidence-base (for a review see Lynn et al, 2000).

**Example:** “Lisa... had suffered grievous losses in the preceding two years. First her mother died of cancer ...” Then “her father died of a heart attack... ‘I felt heart-broken when my dad died... and I became very ill’...she lost her job. Then her brother... died of lung cancer.” Graber (2004, p. 158-160) asked Lisa to “look for a time in your life when you felt loved, protected, and cared for - not necessarily by your immediate family.” ... Lisa: “Yes... when I was a little girl... Our neighbours were Catholic, and they had built a little shrine in their backyard. ... I always felt so at home there – very safe, protected, and loved! ... We tapped into that memory and made it more vivid and accessible through multi-sensory imagery.” She practised this technique at home and explained that she had family reunions there which helped her overcome her sleep problem.

**Exercise:** Develop your own **Logoanchor.** Exchange notes with your colleagues.

**Love:**

**Description:** Boniwell (2006) describes **Love** as the need to belong and have close connections to others combined with needs for expanding the boundaries of the self.

**Background:** As part of the virtue cluster of ‘Humanity’, the CSV concept of **Love** involves at least three facets: **Love** for others who mainly provide for (almost) all our needs, such as child’s love for a parent. **Love** towards those we care for, e.g. parent’s love for a child. And passionate/romantic **Love** (Peterson and Seligman, 2004). In addition, Boniwell (2006) describes other aspects such as **Love** based on mutually beneficial and enjoyable exchanges as in friendship, selfless **Love,** and pragmatic **Love,** which seeks to come to know the other to ensure partners are compatible in terms of aims, expectations, values, and lifestyles etc. **Compassion**, acceptance, respect and growth as well as **Authenticity** all come into play.

Evidence-Base: Research evidence is available for emotional bonds and attachment. It shows that “securely attached adolescents and adults cope more effectively with the stresses of life and are more skilled at forming social ties that are enduring, satisfying, and are characterized by trust and intimacy. Both of these skills predict better psychological adjustment and physical health.” (Peterson & Seligman, 2004, p. 315).

**Example:** Most clinicians will have an example of a severely depressed client whose partner was strongly committed and would love and care for the client through thick and thin. The following is an example of how **Love** can help heal wounds, be they physical, emotional, psycho-social (e.g. political) or spiritual:

> I was Israel’s consul in Milan (1956/1958), when Italy celebrated the 10th jubilee of its liberation. One day I receive a letter signed by 27 people from Israel...: They spent 23 months of their lives in a cellar of a Franciscan monastery and owe this fact their survival. And now, ten years later, they wish to return ..., to pay the nuns a visit of gratitude... she says...Herr Consul, are you Communists or are you Fascists?... in the cellar down there, which we showed to you – where the nuns ... baked matzos twice ..., so the Jews in the cellar would not only live, but could also celebrate a Passover -, in the same cellar, 600 metres away from the Gestapo office, we were hiding communists in 1942, Jews 1943-1945,
Exercise: By showing unconditional positive regard, the therapist lays the foundation for clients’ self-love. Therapists’ own PPD* needs are to foster their own self-love, so they can truly give of themselves. In addition, Socratic Dialogue* can be utilised to detect who in the client’s life might have loved them unconditionally, even if only for a fleeting encounter. Such discoveries can enrich clients’ lives immeasurably.

Making a Difference:
Description: Taken from Covey (2004), the idea is to try and have a (positive!) impact wherever life puts the person.
Background: Logotherapy* holds that the person cannot demand anything from life anything. Rather, it highlights life’s task quality, which, when taken upon oneself, inadvertently leads to Happiness* (e.g. Chan, 2008). Zohar and Marshall (2004) describe in their book on spiritual capital about their wish to live one’s life so as “to leave the world a better place.” (Zohar & Marshall, 2004, p. IX). Overlapping with the question of the human Spirit* and spirituality, Making a Difference is about using the human potential given to each person for the benefit of mankind.
Evidence-Base: Zohar & Marshall (2000) develop their Spiritual Quotient (SQ) from neuroscience and: “According to quantum field theory, we have seen, each of us is an excitation of energy, a pattern or wave on the ‘pond’ of the vacuum. We cannot draw a boundary between the waves and the pond, nor can we draw any hard and fast boundary between ourselves and other ‘waves’… all of us are individual forms that contain the same centre… High SQ requires me to use my deep spontaneity to respond to all others and to all existence, and to take responsibility for my role in caring for these things.” (Zohar & Marshall, 2000, p. 291).
Example: “One time I was leaving a military base where I had been teaching principle-centered leadership over a period of time. As I was saying goodbye to the commander of that base, I asked him, ‘Why would you undertake such a significant change effort to bring principle-centered living and leadership to your command when you know full well you will be swimming upstream against powerful cultural forces? You are in your thirtieth year and you are retiring at the end of this year. You have had a successful military career and you could simply maintain the successful pattern you’ve had and go into your retirement with all of the honors and the plaudits that come with your dedicated years of service.’... He said, ‘Recently, my father passed away. Knowing that he was dying, he called my mother and myself to his bedside. ... My father said, ‘Son, promise me you won’t do life like I did. Son, I didn’t do right by you or by your mother, and I never really made a difference. Son, promise me you won’t do life like I did.’... ‘I want to honor the greatest legacy my father gave me, and that is the desire to make a difference’. (Covey, 2004, pp. ix-x).
Exercise: Use Frankl’s maxim: “Live as if you were living already for the second time and as if you had acted the first time as wrongly as you are about to act now!” (Frankl, 1985, pp. 131-132) either with your client/s and/or for your own Personal Professional Development*.

Meaning in Life:
Description: This is a central concept in Logotherapy looking at if and where clients see their meaning and what Values* they hold.
Background: Also known as Purpose in Life (PIL), this is what Frankl found to be at the core of many difficulties. Frankl assessed his (formerly) suicidal patients using two questions:
a) *Do you (still) have suicidal intentions* – If patients confirm this, they cannot yet be discharged. If they deny it, the clinician asks the next question:

b) *Why don’t you (any longer) wish to take your life* - The answer to the second question is vital as it helps discern dissimulating patients from genuinely recovering clients. The former will find it difficult to answer the second question, whereas the latter will have many strong reasons for surviving such as responsibility towards loved ones or one’s work duties, hope for recovery, religious or spiritual reasons etc. (Frankl, 1999).

**Evidence-Base:** There is a vast research literature on **Meaning in Life** (Batthyany & Guttmann, 2005), employing a variety of measures such as the Logo-Test (Lukas, 1986b), Purpose In Life Test (PIL: Crumbaugh & Maholik, 1964), and **Meaning in Life Questionnaire (MLQ)** (Steger, Frazier, Oishi & Kaler (2006), to name a few. The PIL is used as an outcome measure by many Logotherapy practitioners and –researchers (e.g. Lantz & Gregoire, 2000; Lantz & Harper, 1988; Whiddon, 1983; Zuehlke & Walkins, 1975).

**Example:**

> Nancy Goodman came for counselling... she possessed the fullness of material success, she felt empty in spirit... Following the divorce Nancy embarked upon a major effort to find herself. During the next two years she tried many things... politics... religion... affair... Finally, it occurred to her that she was running from something within herself, rather than toward something. Of course, she had marginally known this all along, but would not face it until she was exhausted from the flight. This was when she came for help. After having read Frankl’s book... she was ripe for the... awareness that she needed guidance in working herself out of the fog... 'Do you know ...Mount Kilimanjaro?... in the twenties a party of explorers ... found near the top the dried and frozen carcass of a leopard. No one has ever explained what the leopard sought at this altitude. But from this simple story... in the public press, Ernest Hemingway spun one of his greatest stories... The Snows of Kilimanjaro. The story ... contains in a nutshell the whole picture of man's search for meaning in life... The hero was a writer, Harry, who had been unable to write for awhile... In an effort to find inspiration, he returned ... to an accessible level on Mount Kilimanjaro, because he had once been there during his most productive period. The mountain had become the mystical symbol of the elusive quality of meaning in life, the meaning Harry had struggled without success to find. He thought that once he was back on the mountain, things would begin to fall into place. But he contracted blood poisoning, transportation broke down, and ... they sent for help. The help did not arrive on time, however, and he died. His last thoughts were a fantasy that a plane came to take him ... into the snowcapped summit... Harry experienced a revelation that the peak contained the ultimate meaning of life, which he was at last going to understand.... I am going to give you a series of exercises as homework assignments.'... At first Nancy thought some of them made little sense; others were fun; and to still others, she was indifferent... A few months passed before Nancy began to see where her real hang-up had been, the blocking factor... she must discover for herself... The answer was elementary: In spite of her lifelong reaction against the establishment, her deepest feelings were quite conventional... She really wanted a stable marriage, children... She also needed the additional creative outlet of a cause in whose behalf she could find a unique identity apart from her family... Nancy did develop plans for the accomplishment of both roles, and she did lose her emotionally charged negativism toward traditional society... She met a physician ... who worked with the underprivileged. This friendship forged her interest in becoming a graduate social worker.” (Crumbaugh, 1973, pp. 149-156)

**Exercise:** Complete the MLQ and reflect on your answers using your Reflective Journal. Please take a moment to think about what makes your life feel important. Please respond to the following statements as truthfully and accurately as you can, and also please remember that these are very subjective questions and that there are no right or wrong answers. Please answer according to the scale below:
Meaning Transformation:

Description: Changing the meaning of certain behaviours, events or emotions can often be crucial to progress in psychotherapy.

Background: Power & Brewin (1997) explore this concept from different psychotherapeutic models. They find that it is a vital part in many, if not all psychotherapies.


Example: Jerkins’ case of a man with alcoholism and multiple personality disorder illustrates Meaning Transformation utilising the VAT (Hutzell & Eggert, 1989):

The host personality’s and alter’s responses showed striking dissimilarities at step one of the VAT. For example, the host personality first listed “nurse or doctor” as a job he would like, while the alter responded “mercenary”. In exploring the reasons for each choice, however, overlapping values became apparent – both responses included values of crisis handling, independence, and challenge. Similarly, the host personality chose his grandmother and wife as having a positive influence on him, while the alter included “Chuck Norris” and “Sylvester Stallone” – obvious surface differences, but some shared underlying values such as strength and being capable. The VAT helped the alter realize that he had more breadth to his role than just rage and protection... The alter spontaneously commented after one exercise: “so much about me I never thought about... you’re making me see that I’m not such a hard guy after all.” This realization, when conveyed to the host personality, appeared to lessen the host personality’s fears of the alter acting inappropriately. Thus he was more willing to let the alter fuse with him in carefully graduated periods of time... After six months of outpatient followup, the patient presented no signs of dissociation.” (Hutzell & Jerkins, 1990).

Exercise: Read the following poem. How could you utilise its message with clients (possibly amending it slightly depending on the clients’ belief system, e.g. “I asked for strength and was given difficulties to make me strong... “)?

“I asked for strength and G-d gave me difficulties to make me strong.
I asked for wisdom and G-d gave me problems to solve.
I asked for prosperity and G-d gave me brawn and brain to work.
I asked for courage and G-d gave me dangers to overcome.
I asked for love and G-d gave me troubled people to help.
I asked for favors and G-d gave me opportunities.
I received nothing I wanted.
I received everything I needed.
My prayers were answered.” (Anonymous; cited in Y.M.G., 2005)

Meaning Triangle:
Description: This is a triangle which describes ways of finding meaning in life:

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Creativity

Experiencing

Attitudinal Change
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Figure 9: The Meaning Triangle (based on Frankl, 1985)

Frankl (1985) found Creativity*, Experiencing something/-one* and Attitudinal Change* to be the main vehicles of finding meaning in one’s experiences.

Background: Logotherapy holds that these three areas of interacting with life’s challenges potentially provide man with meaning. The Values Awareness Technique (VAT) aims at giving therapists and clients practical tools in discovering values and meaning potentials (Hutzell & Eggert, 1989, see example below).

Evidence-Base: The authors are aware of anecdotal evidence for the helpfulness of this approach (see example below).

Example:
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“A 38 year-old woman was hospitalised as anxious and suicidal... She denied significant problems in her life (in spite of her current circumstances)... The first author was consulted, and he determined that a second personality was present... The therapist built rapport and was able to get Minnesota Multiphasic Personality Inventories (MMPI’s) completed by the host personality and the alter. Both MMPI’s proved to be valid. The host personality’s profile suggested an individual who tended to deal with anxiety through physical symptoms and who was immature, egocentric, suggestible, demanding, shy, and moderately distressed. The alter’s personality profile suggested a sullen, angry, rigid, blaming individual. Her alter was also a 38-year-old woman. Her first and last names were different... The alter reported she had split off at age 8 as a result of sexual abuse. Since then she served as a protector and acceptor of pain. The alter stated she recently began fighting for control of the host body because the patient was too passive... The alter had revealed herself and her plans to the host and her family... The therapist expended considerable effort to get the alter to agree to therapy for the host personality... Hypnotic abreaction began... After two weeks of daily hospital treatment, the patient was discharged to home. The therapy switched to weekly outpatient sessions... The host personality received training in various life skills, including stress inoculation and assertion training. The issue of fusion was introduced, but both the host personality and the alter... viewed each other as so dissimilar that neither was willing to consider incorporating any of the observed qualities of the other. So, the VAT was introduced to discover similarities in```

values and areas of apparent incompatibility. The VAT items employed were: 5 jobs you would like, 5 hobbies you would find interesting, 5 of the most satisfying experiences you have had, 1 favorite experience for each of the five senses, 5 occasions when you took responsibility, 10 persons who have had a positive effect upon you. The resulting value clusters ... resulted in their determining they had substantially more similarities than they had believed. Further, they determined that their differences were not incompatible and indeed might be complementary. It was at this point that both decided to seriously consider and work on fusion... [Through negotiations with and between host and alter – added by first author] the patient arrived at therapy stating that host personality and alter had fused themselves together permanently...Her husband was able to take independent trips and for the first time in their 20 years of marriage, felt comfortable leaving her at home alone several days at a time to care for the children. The final session... included her family, and all agreed that further therapy seemed unnecessary... The family physician (the initial referral source) reports there has been no indication that she should return to treatment (Hutzell & Jerkins, 1990, pp. 89-91).

Exercise: Use your Reflective Journal to explore the following questions
“...for clarifying Creative Values...:
- What job have you held longest?
- What hobby have you not pursued but think you might like?
- How would you complete the following? ‘It would be fun...’

Helpful Questions for Experiential Values include:
- What is a recent event you attended because you wanted to?
- What is one of you favourite things to look at?
- What is one of the most satisfying experiences you have had?

Fruitful questions for Attitudinal Values in
- What person has had a significant positive effect upon your life?
- What epitaph would you want on your tombstone?
- When did you take an unpopular stance on an issue?" (Hutzell & Jerkins, 1990, p. 89; see also Hutzell & Eggert, 1989).

Note the reason/s for each of your answers. Now classify your answers according to value clusters, e.g. the 24 character strengths from the CSV (Peterson & Seligman, 2004). What pattern emerges?

Narrative Logotherapy:

Description: A set of logotherapeutic techniques which help clients tell their story. It “explains how through listening, and careful reflection, therapists can recognize and aid their patients’ will to finding meaning, and guide them toward areas in which meanings can be found.” (Mendez, 2004, p. 143).

Background: Mendez (2004) describes the following examples:
- Key Words: The therapist listens carefully to the client’s usage of words, thus helping them detect the purpose and meaning of their struggles, e.g.: A client became dissatisfied with life at the peak of her career. “I am well off” the client reported. The therapist asked whether she had always been well off, having noticed that it seemed to the client that this being well off should provide all the happiness she would wish for. Thus, they discovered that the client lacked a goal to strive for which she had had up to this point in time. (Lukas, 1986a).
- Careful Differentiation: Helping clients to see nuances avoiding overgeneralisations.
- Naïve Questioning: This can be done to overcome unfounded guilt, e.g. when a mother
felt guilty for having dressed her daughter warmly in the winter as she developed recurrent bronchitis, the therapist used Naïve Questioning, asking whether she should have sent her out in the cold with summer clothes (Lukas, 1986a).

- Symbols and Metaphors: Helping clients develop metaphors, asking what this situation reminds them of, being encouraged to draw on any experience they may have had or heard of (see example below).
- Illustrating Meaning Possibilities: These can be future meanings or can include that there is nothing to be done; sometimes these can be explored by using the arts, literature or (disguised) stories from other clients.
- **Socratic Dialogue*** (see separate entry below).

Evidence-Base: Carl Rogers was one of the first psychotherapists to emphasise the importance of emphatic listening. Power & Brewin (1997) see Meaning Transformation* at the root of psychotherapy success.

**Example:** A Native American patient recalled the migration of the salmon up the streams of wild rivers in Canada. He likened his vexation and indecision about the direction he should take in life, with a salmon caught up in a swirl-pool of water, and unable to advance higher up. By visualizing how the fish gathers up all its strength to “jump” to the next level, he realised that he has to learn how to avoid certain obstacles which were slowing him down; such as he needed to find a way to manage his anger more effectively, not to end up in fights, which in the past cost him his job, and relationships. He needed to learn how to put himself “above” the forces of anger, and use his energies to propel him to “advance.” (Mendez, 2004, p. 154).

**Exercise:** Choose some of the techniques mentioned above and try them out, using your Reflective Journal as a platform and record of your efforts.

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**Noögenic neurosis:**

**Description:** (from Greek ‘noös’: mind) ‘denotes anything pertaining to the specifically human dimension’ (Frankl, 1985, p. 123). Often translated as ‘meaning’, this neurosis is due to a perceived lack of purpose.

**Background:** Noögenic neurosis comes from existential problems, ‘the frustration of the will to meaning plays a large role’ (Frankl, 1985, p. 123). The Purpose In Life Test (PIL: Crumbaugh & Maholik, 1964) and other Meaning in Life* measures are designed to assess the degree of the client’s meaning fulfilment at intake, conclusion and follow-up.

**Evidence-Base:** For assessment of Noögenic neurosis: See evidence for Meaning in Life* measures above.

**Example:** “Claire reports feeling a total loss of meaning. Now that she has stopped trying to please others..., she is experiencing a void. ‘Even though I have lots of friends, I feel basically alone; no one else can make my decisions, and I, alone, am responsible for how my life turns out...’” (Ingram, 2006, p. 230). In the next example, the client explores experiential and creative values which help her start overcoming her meaning crisis: “Violet describes feelings of emptiness, meaninglessness, and stagnation. However, she discovers that when she looks at beautiful scenery she feels awe and a sense of reverence. She starts going to an art class and discovers she has ‘come alive’. During those 3 hours each week, she feels like she has rediscovered the spontaneity and joy that were lost in childhood.” (Ingram, 2006, p. 268).

**Exercise:** Consider utilising a Meaning in Life* measure to ascertain the degree of perceived
meaningfulness of clients’ lives. Art, literature, music etc. can help clients overcome limited meaning perception. Worries about the past can decrease by considering the saying: ‘Today is the first day of the rest of your life’, encouraging clients make a fresh start and overcome Noögenic neurosis.

**Obsessive-Compulsive Disorder (OCD):**

**Description:** DSM IV lists the following criteria:

A. Either obsessions or compulsions:

**Obsessions as defined by (1), (2), (3), and (4):**

(1) recurrent and persistent thoughts, impulses, or images that are experienced at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

**Compulsions as defined by (1) and (2):**

(1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person’s normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

**Background:** Frankl (1999) describes how obsessions are characterised by fighting against the symptoms, i.e. the obsessive thoughts, as clients are afraid of becoming psychotic or of committing a crime (i.e. of actualising the content of their obsessions). Pressure creates counter pressure which in turn increases the pressure (see Figure 10 below).
Thus, treatment is designed to – as a patient once put it- “Take the bull by the horns” (Frankl, 1999, p. 22; translation by the author) by instructing clients to intend what they have dreaded so far. Thus, they counteract their perfectionism (Frankl, 1999).

Table 10: Summary of NICE Guidelines (2004) for Self Harm

<table>
<thead>
<tr>
<th>General Principles</th>
<th>Treatment</th>
<th>Psychosocial assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always treat people with care and respect. Ensure privacy for the service user. Take full account of the likely distress associated with self-harm. Offer the choice of male or female staff for assessment and treatment. Always ask the service user to explain in their own words why they have self-harmed. Don’t assume it’s done for the same if witnessed on several occasions. Involve the service user in clinical decision-</td>
<td>Offer psychosocial assessment at triage to determine the following: mental capacity, willingness to remain for further psychosocial assessment, presence of mental illness. If a person wishes to leave before a psychosocial assessment, assess for mental capacity/mental illness and record assessment in the notes.</td>
<td>Assess needs and risk as part of the therapeutic process to understand and engage the service user. Consider integrating needs a risk assessment. Record assessment in the service users notes. Share written assessment with the service user. If there is a disagreement, consider offering the service user the opportunity to write this in the notes. Pass assessment on to the service user’s GP and to any relevant mental health services to enable follow up.</td>
</tr>
</tbody>
</table>
Evidence-Base: SPC has found strong research support for Exposure and Response Prevention as well as Cognitive Therapy for OCD. NICE guidance suggests:

Table 11: Summary of NICE Guidelines (2004) for Obsessive Compulsive Disorder (OCD)

<table>
<thead>
<tr>
<th>Step 1: Awareness and Recognition</th>
<th>Step 2: Recognition and Assessment</th>
<th>Step 3-5: Treatment options</th>
</tr>
</thead>
<tbody>
<tr>
<td>All PCT’s, healthcare trusts, and children’s trusts should have access to a specialist OCD multidisciplinary team offering age-appropriate services.</td>
<td>Explore possibility of comorbidity in OCD sufferers, including symptoms of depression, anxiety, alcohol or substance misuse. Assess the risk of self-harm and suicide, whilst including the impact of compulsive behaviours. Consider the psychosocial factors that may be contributing to the risk.</td>
<td>Mild functional impairment OR Low intensity approach: CBT (less than 10 hours) – brief individual with structured self-help materials or group therapy, this may be greater than 10 hours. Moderate functional impairment: Choice of either a course of SSRI’s or more intensive CBT Severe functional impairment: combination of SSRI’s and CBT (Exposure &amp; Response Prevention). If there is still an inadequate response after 12 weeks or no response to SSRI’s alone, then</td>
</tr>
<tr>
<td>Psychological Interventions: All providers of treatments should have appropriate training in these interventions, with ongoing clinical supervision in line with recommendations in organising and delivering psychological therapies. Advice to patients who request alternative forms of psychological therapy, such as, psychoanalysis, transactional analysis, hypnosis, that there is no convincing evidence to support their use.</td>
<td>-Obsessive thoughts without overt compulsions: consider CBT with exposure to excessive thoughts and response prevention of mental rituals and neutralising</td>
<td></td>
</tr>
</tbody>
</table>
Supplementing these recommended treatments with **Paradoxical Intention** may help improve clients' recovery (see example below).

**Example:**

Mr M. P. is a 56 year-old solicitor ... 17 years ago, “the terrible obsessive thought came like a flash of lightning out of nowhere”, that he might have assessed his income tax 300 Dollars too low and thus might have committed fraud towards the state – although he had completed his inland revenue assessment to the best of his knowledge and ability. “I was unable to get rid of this idea - as much as I tried”, he said to Dr Gerz. He saw himself being persecuted for fraud, out into prison, saw the newspapers full of articles about him and saw himself losing his job. He ... was first treated with psychotherapy and then with 25 electroshocks - unsuccessfully. In the meantime, his situation worsened to such an extent, that he had to close his solicitor’s practice. In sleepless nights, he had to fight with obsessions, which increased daily... He especially had the obsession his various insurance contracts might have expired without him noticing it. He had to check them again and again ...Finally, he signed a specially for him developed super-insurance at Lloyds in London which was going to protect him from consequences of any unconscious and unintentional mistakes... the patient had to be admitted to the psychiatric clinic of Middletown... paradoxical intention treatment with Dr Gerz started. Over four months, he applied three weekly Logotherapy sessions. Again and again, he was instructed to use the following paradoxical formulation:”... I am happy with everything – I don’t mind going to prison. The sooner, the better! Should I worry about the consequences of a mistake I might have made? They should arrest me – every day three times! At least I’ll get my money back... ”... Dr Gerz ... used to greet him in his surgery: ”What – for heaven’s sake! You are still running free? I thought you were long behind bars – and I have already looked in all the papers to see whether they still haven’t reported on the big scandal that you caused!”... Now it is more than a year ago that his treatment is finished: ”These formula – what you call paradoxical intention, doc – that ... has worked like a wonder ...: In four months you have made a different person out of me. Of course, every now and then one of my old worries comes in my mind; but, you know, now I can deal with it right away – now I know how I have to handle it!”    (Frankl, 2004, pp. 61-62; translation by the first author).

**Exercise:**

You might like to try the following exercise on yourself. (One can’t get a grip on these exercises till one uses a concrete example) ...

Many times we have experiences that leave us feeling very obsessive in our thinking. The basis of the thought here is that we feel that way because our identity reflected something unpleasant to us that we don’t want to be associated with...

By re-clarifying and strengthening the identity that we **DO** wish to be associated with... we can emerge more strengthened and empowered.

Since there is good and bad in everything, by definition, we’ll find **Part** of the experience was good (perhaps it was our original **motivation** that was good), but then the bad turned out so bad (embarrassing or regretful), that it seems **impossible** to make peace with it, and we get stuck there, and can’t seem to break away and move forward.

1. What are the parts of the experience that you **DID** like?
2. What are the parts of it that you did **NOT** like, or have left you feeling uneasy?
3. If you could turn the clock back, what would you do differently?
4. Taking this into account, what has this experience given you the opportunity to know with more conviction or certainty?
5. What values would you be honouring in this preferred behaviour?
6. What do these values say about the person who feels them?
7. Based on this experience, and the strong convictions that have emerged as a result of it, can we see a clear goal taking shape here? If yes, what might it be?
8. If this experience were to significantly help you to achieve this goal, would it have been a worthwhile investment to have had the experience you described?
9. If yes - Does this in some way reflect to you how much value you attach to this goal?
10. If we were to come up with an action plan right now ....which few points would clearly reflect that you were moving in the direction of this goal?
11. If you were successful in integrating these values into your character, how else would people see them manifested in your life?
12. What have you gained through going through this experience so far?
13. Fill in the applicable boxes:

Having gone through this experience I see myself emerging....
☐ Unchanged ☐ Just as stuck and helpless as before ☐ With bruised self respect
☐ With self-condemnation
☐ With deeper sensitivity ☐ With clearer knowledge of my values and identity
☐ More goal directed ☐ Enriched ☐ ‘bigger’ or ‘higher’
☐ More at peace with self ☐ With more self-respect

14. This recognition of my “human spirit in growth” allows me to: (tick where appropriate)
☐ Forgive myself
☐ Respect myself despite my not being perfect
☐ Forgive others
☐ Judge others with more insight and compassion, as I focus on their ‘mid growth’ state...
☐ Believe that I can grow in many other ways too.
☐ Believe others may be struggling and yearning to break through some of their limitations too.

15. How would you describe your attitude to yourself concerning the way you have worked through this unpleasant experience?
16. What positive qualities do you now recognize you have in your ‘makeup’ that you will now be able to work with, that you were unaware of possessing before?
17. Write about this new self-knowledge in a pad for future reference and for future work. (Kruger, 2010)

Optimism:
Description: “Optimists are people who expect good things to happen; pessimists are people who expect bad things to happen.” (Carver & Scheier, 2005, p. 231).
Background: Logotherapy uses the term Tragic Optimism (Frankl, 1985) to denote making the best out of the given circumstances, though acknowledging that they may be tragic. Man is able to respond to the Tragic Triad* by making the best (‘optimum’) out of tragedy (e.g. Frankl, 1985; Greenberger, 2003).
Positive Psychology has conceptualised Optimism as positive emotion (see Hope*), as the expectancy that good things will happen (Carver & Scheier, 2005, see above), and as explanatory style -coming from Seligman’s learned helplessness research, Seligman, 1975-, attributing good events to internal, stable, and global factors and negative events to external, unstable, and specific reasons (Seligman, 1990). Optimism can be learned and trained, and is nurtured in happy, supportive families with parents who themselves have optimistic explanatory styles (Peterson & Steen, 2005). Teacher’s explanations about success and failure as well as media’s coverage of violence may lead to pessimistic explanatory styles (Nolen-Hoeksema, 1987).
Evidence-Base: Several measures have been developed to measure Optimism. In a study of 292
university students, Salmela-Aro et al. (2009) showed that “high and increasing optimism during university predicted a high level of work engagement and low level of burnout 10, 14 and 17 years later”, preventing task-avoidance and burnout (Salmela-Aro et al., 2009, p. 162). In another study, those expecting productive outcomes were more willing to make compromises and were also more satisfied with the negotiation process (Liberman, Anderson, & Ross, 2010).

Example: Pransky (2001) describes how he saw a delinquent adolescent for therapeutic sessions the judge had convicted him to attend. Throughout the first nine sessions, the young person sat like a statue with a look of disdain on his face, while the therapist was talking about the young person’s potential, his innate wish to be useful and helpful, giving examples etc. Then, the young person burst out crying saying the therapist was wasting his time, he was no good. Yet despite this, a working relationship developed and headway was made. By a firm optimistic stance regarding the innate goodness of his client, he enabled him to transform his life and reach his potential.

Exercise: Assess yourself using Optimism International’s creed (http://www.optimist.org):

- To be so strong that nothing can disturb your peace of mind.
- To talk health, happiness and prosperity to every person you meet.
- To make all your friends feel that there is something in them.
- To look at the sunny side of everything and make your optimism come true.
- To think only of the best, to work only for the best and to expect only the best.
- To be just as enthusiastic about the success of others as you are about your own.
- To forget the mistakes of the past and press on to greater achievements of the future.
- To wear a cheerful countenance at all times and give every living creature you meet a smile.
- To give so much time to the improvement of yourself that you have no time to criticize others.
- To be too large for worry, too noble for anger, too strong for fear, and too happy to permit the presence of trouble.”

Boniwell (2006) adds:

- “...having confidence that even if things don’t go your way, you will be able to deal with the situation (or even somehow benefit from it). (Boniwell, 2006, p. 20).- Reflect on the possible effect therapists who are able to model such Optimism may have on their clients. Record your thoughts in your Reflective Journal and discuss them with colleagues.

Paradoxical Intention:
Description: Also called reverse psychology and prescribing the symptom (e.g. Ingram, 2006), this logotherapeutic technique encourages wishing for your worst fears to come true, relying on exaggeration and Humour* (e.g. Frankl, 1985).

Background: Attempting to do that which one is afraid of takes the threat out of the situation, thus relieving the person of the symptom. It is important to explain to the client that the recommendation they are about to get might sound quite far fetched. However, research evidence is strong, thus making this technique at least worth a try.

Contraindications: Highly depressed, suicidal patients/clients.

Evidence-Base: Several randomised-controlled trials (RCTs) provide strong evidence for the effectiveness of this logotherapeutic technique (e.g. Michelson at al, 1990; Espie et al, 1989; Ascher & Turner, 1980). A review by Fabry (2010) showed that it is an effective, evidence-based
treatment for various areas, including **Insomnia***, agoraphobia, incontinence, conversion reaction, anorexia nervosa, and public speaking anxiety. This highly effective technique is one of “three treatments which meet American Psychological Association (APsA) criteria for empirically-supported psychological treatments for insomnia” (Morin et al, 1999, p. 1134). Another review by Michelson & Ascher (1984) confirms that there is good evidence for the effectiveness of **Paradoxical Intention** in agoraphobia and other conditions as the person with agoraphobia tries to “control the activity of his sympathetic nervous system. In contrast, since paradoxical intention eschews ‘coping’, failure does not occur and panic is not typically experienced” (Michelson & Ascher 1984, p. 215).

**Example:**

George Pynummootil (USA) reports the following: ”A young man came to my surgery because of a severe tic of blinking his eyes, which appeared whenever he had to speak to someone. As the people used to ask him what the matter was, he became more and more nervous... I recommended to him that the next time he had to speak to someone he should blink as much as possible in order to show the other person how good he was at it. He, however, said I must be out of my mind recommending this, as it could only worsen his situation. And he went. He then came back one day, in order to tell me very excitedly what had happened in the meantime. As he had not approved of my suggestion, he had not considered acting on it. The blinking became, however, worse, and when he one night remembered what I had said, he told himself: Now I have tried everything on offer, and nothing has helped. What can happen – I’ll just try what he recommended. The next day, when he met the first person, he planned to blink his eyes as much as possible – and to his greatest surprise, he was unable to do so. From then on, his blinking tic never re-occurred.” (Frankl, 2004, p. 58; translation by the first author).

**Exercise:**

a) Identifying an area of anxiety, try your utmost to go for the anxiety, exaggerating it for good measure! What happened? Reflect on this experience in your Reflective Journal.

b) Having practised it yourself, you are now able to more fully empathise with your clients when suggesting **Paradoxical Intention**.

**Person:**

**Description:** Logotherapy views the human being in a special, humanistic way, which is the foundation of this “caring and compassionate approach to health care” (Mendez, 2004, p. 50).

**Background:** “Frankl summarised “Ten Theses on the Human Person”, applicable to all human beings in all circumstances…”

*Every person is an Individuum.*

*Every person is not only in-dividuum [in-divisible, can’t be divided – comment by the first author], but also in-summable [can’t be summed up-comment by the first author];

*Every person is an absolute Novum (new creation);

*Every person exists in spirit [exists in the specifically human dimension of the spirit above and beyond body and mind – comment by the first author];

*Every person is existential [exists in the here and now and has to face the human condition, e.g. suffering, guilt, and death, - comment by the first author];

*Every person is basically self-directed;

*Every person is a united whole (of body, mind, and spirit) [rather than the sum of those parts - comment by the first author]

*Every person is dynamic [is flexible and changes - comment by the first author];

*Animals are not persons [they do not have a human spirit - comment by the first author];

*Human beings understand themselves to the extent that they transcend (reach beyond) themselves.” (Mendez, 2004, pp. 50f.).
Evidence-Base: These more philosophical humanistic underpinnings of Logotherapy are shared with other humanistic approaches such as Positive Psychology. They are also the foundation of CBT (see Benware, 2003; Fabry, Sheikh, & Selman, 2007).

Example:

“I don’t like working with maggots,” Rick said to me as we were discussing his current job and career aspirations. Working as a probation officer for the state department of corrections, Rick, believe it or not, was referring to his clients! He had worked in his current position for over four years and had not, he said, changed his views about the people with whom he was in daily contact – people who, obviously, depended on him for advice and support.

After some probing, I learned that Rick had grown up as a ward of the state, bouncing between various sets of foster parents with periodic stints in an orphanage. But, rather than becoming sympathetic and compassionate to those in need, Rick’s experience resulted in just the opposite outcome – he became insensitive and unforgiving. Unlike many people who have gone through similar situations, Rick didn’t relate (and did not want to relate) to people who, in his view, weren’t able to take care of themselves, who “slurped at the public trough” – that is, who depended on public assistance.

After graduation from college with a degree in finance, Rick took the first-time job that was available. “Anything would be better than busing tables or flipping burgers,” he thought to himself… Since he needed the full-time work experience anyway, and he figured that he would find something better soon, Rick, the probation officer and human services warrior, came to be.

Right off the bat he knew that this kind of job was not for him. Yet he felt trapped. Working full-time for a regular salary was new to him and he liked it – the regular salary, that is. … Most of his friends were envious of him, and Rick soon found himself on cruise control. He didn’t need to feel; he only needed to put in the hours… (Pattakos, 2004, pp. 155-156).

Exercise: In your Reflective Journal, note down how you relate to the above ‘Ten Theses on the Human Person’ (see Maas, 2002). What implications does this have on your work with clients (see also Fate-Freedom Balance*)?

Personal-Professional Development (PPD):
Description: PPD is an acknowledgement that clinicians’ professional development and their personal growth are intertwined and affect each other. It means engaging in activities which foster self-awareness, reflection, and enhanced professional effectiveness (Sheikh, Milne & MacGregor, 2007).

Background: PPD fosters Resilience* thus preventing burn-out in clinicians who are exposed to significant levels of stress and in danger of vicarious traumatisation (Jenkins & Baird, 2002). Ungar et al. (2000) describe how logotherapists need to look after themselves. Ernzen (2001) did a survey of logotherapists’ PPD activities and their effect on them, showing the need – and indeed tendency - to ‘practice what you preach’. Meaning Transformation* in effect increases the depth and breadth of any PPD exercise, being at the core of engaging with PPD (see example). Sheikh, Milne & MacGregor’s (2007) three main dimensions of self-awareness, reflection, and enhanced professional effectiveness leave a gap between increased awareness & reflection on the one hand, and enhanced professional effectiveness on the other. How are increased self-awareness and reflection increasing professional effectiveness? Fabry (2008) postulates that this is brought about through the mechanism of Meaning Transformation*, which is similar to what is happening in therapeutic work.

Evidence-Base: Bennett-Levy (2006) showed that cognitive therapist skills can be enhanced by self-practice and self-reflection. Further research is required for this as well as other PPD experiences.
Example: A teacher did not spend much time on PPD activities due to work pressures. However, this led to becoming ill and having to be off work. Paying close attention to the meaning dimension of any PPD experience will help to transform PPD activities into what they rightfully are meant to be: Supportive and growth-enhancing experiences.

Exercise: Describe a recent PPD activity you engaged in. Can you detect the above-mentioned components of Meaning Transformation* through increased self-awareness and reflection? Did this in turn lead to enhanced professional effectiveness? How does the model fit your situation? Does it provide a new perspective?

Positive Emotions:
Description: Positive Emotions such as “joy, interest, contentment, love, and the like” (Frederickson, 2005, p. 120) have been shown to be beneficial to people’s well-being in many ways such as longevity (Abel & Kruger, 2010).

Background: Logotherapy* has emphasised the importance of focusing on what’s right and valuable (see Frankl, 1985; see also Derefection* above). In Positive Psychology, Frederickson developed the broaden-and-build theory of positive emotions (Frederickson, 2005).

It says that as opposed to negative emotions, which narrow down one’s action repertoire (in order to fight or flee), Positive Emotions help the person develop broader thoughts and action repertoires (see example below).

Evidence-Base: Frederickson summarises her research supporting the broaden-and-build theory as well as findings from pathology, e.g. that manic phases are characterised by broad, expansive thinking typical for creativity (Frederickson, 2005).

Example:
Years ago, while still a full-time professor, I was driving to campus early one morning to teach a class. It was a very peaceful morning, there was no traffic ...
I remember driving down a tree-lined street, with a grass island in center, that had cars parked tightly on both sides. And, coming up the street toward me was a school bus van, the only other moving vehicle in sight. All of a sudden, for no apparent reason, I saw the van veer out of control and crash into one of the parked cars on its side of the street. I couldn’t believe it!

Immediately, I stopped my car and rushed over to the van to see what I could do. The front of the van was crushed and I could see and smell smoke. While I prayed that someone in the neighbourhood had heard the crash and called 911, I pulled the driver, a young woman, out of the vehicle and, as carefully as I could, carried her to a nearby lawn. I could tell she was injured and, even more, upset by what had happened. She began to cry as she said, “Oh no, what am I going to do? I just got this job; my parents are going to kill me!”

Still waiting for someone, preferably an ambulance, to arrive and help with the situation, I was at a loss for what to do at that particular moment. I wanted to keep the young lady as calm as possible. Without really thinking about the consequences, I looked her straight into the eyes and said: “Let’s list ten positive things about this accident.” I started with: (1) there were no children in the school van; (2) there was nobody in the parked car that was struck; (3) neither vehicle had exploded or was on fire (at least not at that point); (4) somebody was around to help her in her moment of need; and (5) she’s still alive and conscious. You get the picture. In any event, by the time we identified only a few of the items on this list of positives about the accident, the driver actually began to smile! And, importantly, when the ambulance finally arrived, and I explained to the emergency technician what we had done while waiting, he said that her shift in attitude had most likely prevented her
from going into shock.

A key lesson to be learned from this experience? Even if you don’t see the cognitive or emotional benefits of maintaining a positive attitude toward a situation you are facing ..., please consider the physiological benefits. One of the real powers of positive thinking is that it is good for your health! (Pattakos, 2004, pp. 50-52)

Exercise: Apply the broaden-and-build theory to an experience of yours, e.g. by relaxation exercises, meditation, prayer, experiencing nature/art/music, using Loganchor*, making yourself smile and sitting in a friendly posture to create positive feelings (Frederickson, 2005), the ‘Ten positive things’ exercise etc. Please add your own ‘mood enhancers’ to this list! Keep it handy for future reference as and when it might help shift the focus!

Post Traumatic Growth (PTG):

Description: A number of clients experiencing traumatic events gather added strength and well-being through a process of adjustment and understanding of a new meaning in their lives.

Background: Long (1997) describes how to transcend trauma and move beyond to higher levels of personal functioning, thus transcending the trauma via lived values. Janoff-Bulman & McPherson Frantz (1997) describe this “journey from terror to fulfilment” (Janoff-Bulman & McPherson Frantz, 1997, p. 92), where the initial assumption of a meaningful world is shattered. Early attempts to blame themselves for any possible neglect on their part are later transformed into the search for a meaningful life “‘I live my life more fully now.’... ‘I spend more time on the important things in life. There’s been a real shift in my priorities.’” (Janoff-Bulman & McPherson Frantz, 1997, p. 98). Stages of therapy include coping with anxiety through relaxation, desensitisation, flooding etc., followed by creative life choices and engagement. Boniwell (2006) describes sufferers having “more confidence in themselves..., improved and stronger relationships (trauma ... as a litmus paper, revealing the value of your relationships),..., greater feeling of compassion... people learn to appreciate anew what they have..., discover meaning or spirituality..., a more coherent and satisfying worldview and life philosophy” (Boniwell 2006, p. 67). They do this by trying to “make sense” of the event. Then follows “cognitive restructuring. The internal world has to be rebuilt anew, often with major alternations in one’s view, even of oneself. This process is more deliberate. If it is absent, and the assimilation of the traumatic experience into one’s life picture does not happen, the person may not be able to come to terms with the event and may also be vulnerable to future negative occurrences” (Boniwell, 2006, p. 67). In addition, people need to choose their attitude to the situation (Frankl, 1985) and accept support from other people. Expressive Writing* and life story writing as well as diaries of changing beliefs are a technique that can aid the process of meaning discovery and the re-writing of one’s life story, becoming a protective factor (Pennebaker & Chung, in press; Tedeschi & Calhoun, 2005).

Evidence-Base: The evidence for PTG work is growing. Baumeister & Vohs (2005) report about various studies showing physical and mental health benefits for people who engaged in discovering the meaning in their situation, e.g. HIV and losing a partner to it, bereavement and psychotherapy.

Example: Irene Kacandes describes “The changed self” after 9/11 in the following way: “The first change I consciously registered in myself was the attitude that I need to be ready to die at any moment. ...Frequently ... I ask myself about the present moment: is it a good one? Such thoughts have led me to be vigilant about attending to relationships; if in the next instant my life will be over I want to leave as much felicity behind as possible. Similarly, I try to take any
unpleasant situation I might be in and discover some beautiful or positive aspect of it, because, again, if it’s going to be my last moment in this world, I don’t want to have spent it in frustration or anger. This attitude fits well, I suppose, with my transformed sense of the future. I became (and remain) incapable of thinking that I know anything about the future. ... I am finally back to making lists of things to do, but each list carries an invisible, insistent proviso – “If I’m around” .... The knowledge acquired during the traumatic encounter changed the individual and there is simply no retrieving the pre-traumatized self. With the help of a supportive family, group of friends, priest, and psychotherapist, I did not try to rein in my grief. For perhaps the first time in my life I was able to turn the volume a notch on my own self-criticism and just accept what was happening to me” (Kacandes, 2003, pp. 177-181).

**Exercise:** Write your life story with one central theme, following the steps as outlined by Boniwell (2006) above (making sense of what led to the event, finding meaning in the suffering, choosing one’s attitude to it, and accepting social support from friends, family, and other people). Note your story in your Reflective Journal, spending sufficient time on detecting meaning in light of the new events in order to integrate any sore points/memories.

**Pyramidal Value System:**

**Description:** This means that the client is fixed on one main value in life. In case it becomes impossible to realise this value, e.g. through illness or other losses, the person may become despondent and lose interest in life.

**Background:** Frankl (1999) explains that idolising certain Values* leads to Despair*. Lukas describes how it is important for healthy living to create a parallel value system with many equally important values and Goals*, so that if one or more of them become difficult or impossible to realise, the clients still have others to focus their energies on.

**Evidence-Base:** In self-regulation theory, goal over-investment is the term used for this phenomenon (e.g. Barton, 2008; for a review, see Maddux, 2005 and Peterson & Seligman, 2004). The ability “…to engage with attainable goals across a range of self-representations provided a particularly strong developmental trajectory; for example, to build new friendships, change jobs, develop new interests…” (Barton, 2008, p. 277).

**Example:** A PPD example of a Pyramidal Value System:

Having just graduated from college with a degree in business administration, Angela was especially excited when she was promoted to a supervisory position at the drugstore where she worked. It was her first stab at being a manager and she in envisioned this promotion as her initial step up the corporate ladder. Of course, she wanted more than anything to do her very best in her new job and prove to her bosses that they had made the right decision ... Right away, Angela proclaimed her intentions for building better teamwork, sharing responsibilities, and improving performance with all of the employees on her shift... “My co-workers are unbelievably lazy...” ... she displayed an extremely negative attitude about work and was quick to point out the failings of other employees... Unfortunately, she became so fixed on - or obsessed with – accomplishing her mission ... that she could only see problems ... to her escalating management dilemma... Angela had become so consumed with her intended outcome ... that she began to observe herself failing to achieve it ... (Pattakos, 2004, pp. 103-104).

**Exercise:** Role-play supporting clients in developing parallel value systems thus overcoming their tendency to idolise one value as in the Pyramidal Value System. In doing so, what do you notice? De-brief and reflect on content and process issues afterwards. Take down notes in your Reflective Journal for future reference.
**Resilience:**

**Description:** “More than 30 years ago, investigators studying children in high-risk environments observed that many children achieve positive developmental outcomes despite adverse experiences … Individuals who achieve these better-than-expected outcomes have been labelled *survivors, resilient, stress-resistant*, and even *invulnerable*” (Yates & Masten, 2004, p. 521).

**Background:** The concept of *Resilience* (or Defiant Power of the Human Spirit) is a core concept in Logotherapy describing the strength of the human being to choose one’s own stance no matter what (Frankl, 1985). Frankl found that human beings are non-linear, so that circumstances cannot predict what the individual will actually do in any given situation. Appealing to this power is a core technique in Logotherapy as it helps the person transcend psycho-physiological conditions and become the product of their decisions rather than their conditions (see Covey, 2004). – Certain emotions have been shown to work much like a buffer against negative affect, thus forming the *Resilience* hypothesis (Boniwell, 2006). It includes the notion that “Enjoyment, happy playfulness, contentment, satisfaction, warm friendship, love, and affection all enhance resilience and the ability to cope…[It] can enhance problem-focused coping, positive reappraisal, or infusing negative events with positive meaning, all of which facilitate fast bouncing back after an unpleasant event.” (Boniwell, 2006, p. 8). *Resilience* enhancing interventions have been focusing on the individual with competence-promoting as well as multifaceted approaches to empowerment, others have emphasised developmental, transitional and lifespan aspects. Context sensitive interventions have focused more on environments, policies, community, education and family aspects (Yates & Masten, 2004).

**Evidence-Base:** Experiments showed that “resilient individuals are expert users of the undoing effect of positive emotions” (Frederickson, 2005, p. 128; see also entry on *Positive Emotions* above). Often called ‘protective factors’ in the literature Peterson & Seligman (2004) have argued that *Resilience* is made up of various factors. When distinguishing between environmental and internal protective factors, many of the latter ones are included in the CSV (Peterson & Seligman, 2004) and in the present book. Thus, evidence comes from almost all of the entries above and below.

**Example:** Helen Keller, the deaf-mute American girl, who despite all odds became a teacher and author, was extremely resilient, thanks also to her determined teacher. – Another example is Dr. Jerry Long, who as a student had become paralysed after a motorbike accident, only being able to move his head. He decided that the accident broke his back but it didn’t break him. He studied psychology and Logotherapy and became a lecturer and therapist. Frankl described him as “a living testimony to logotherapy lived and the defiant power of the human spirit” (Frankl, 1997, pp. 10). – Regarding PPD: “Being a researcher is often more about resilience than brilliance” (Sutton, 2010, p. 448).

**Exercise:** The next time you see clients, emphasise their *Resilience* (or protective factors), e.g. by using the Four-Leaf-Clover Formulation Template (see Figure 5 under *Formulation*). What do you notice?

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**Response-ability/Responsible-ness:**

**Description:** Logotherapy emphasises that man is responsible and able to respond meaningfully to any situation life presents him with.

**Background:** Frankl (1985) developed this concept to show that human beings have immense capacities which need to be unearthed by making the clients aware of their ability to respond to
life’s challenges (also called his ‘psychological credo’, see Mendez, 2004). Therapists remind clients of the task quality of life (Frankl, 1986), giving to life what only they in their uniqueness can contribute. This means that doing wrong is evidence of man’s choice and his ability to do right, too (as doing ‘wrong in a programmed way cannot by definition be termed wrong’, see e.g. S. Quentin prison lectures, Frankl, 1966). It means there is Guilt* (see also Tragic Triad*), which is typically human due to choice, as man is a ‘facultative’ being (Frankl, 1996; translation by the author). Once guilt is acknowledged, there is a way to make amends or compensate. Man has the ability to be responsible for his acts. Thus, Logotherapy’s categorical imperative was coined, making you believe you were living your life again and you could make amends: “Live as if you were living for the second time and as if you had acted as wrongly as you are about to act now!” (Frankl, 1985, pp. 131-132). This is an invitation to make responsible choices. The CBT pie chart for Guilt* (Greenberger & Padesky, 1997) does some of this work by identifying contributing factors, and then encouraging the client to make amends.

Evidence-Base: Autonomy is closely related to this concept and is an integral part of Well-Being Therapy with its quite favourable preliminary evidence (for a summary see Ruini & Fava, 2004).

Example:
The director of the infamous S. Quentin prison, that is close to S. Francisco, had invited me to give a talk to the inmates, who were quite serious offenders. After I had done that, one person in the audience stood up and said, that the people on death row had been prohibited from attending. He asked, whether I could say a few word to one of them, Mr Mitchell, who was going to be executed in the gas chamber in a few days’ time. I was helpless. I was, however, unable to avoid the request. Thus I improvised and said: "Believe me, Mr Mitchell, I can somehow understand your situation. After all, I also had to live for some time in the shadow of a gas chamber. Believe me, however, Mr Mitchell even then I did not even for a moment give up my conviction, that life has a meaning under all and any circumstances. This is so as it either has a meaning – and then it must keep it, even when it is very short. Or it does not have a meaning – and then it could not become meaningful, even if it lasted for a very long time. Even a life, that to all appearances was squandered, can retrospectively, through self discovery, be filled with meaning by growing beyond ourselves." And do you know what I then told Mr Mitchell? I told him the story of the death of Ivan Illich as told by Tolstoy. You know: The story of a man, who is suddenly confronted with the fact that he does not have much longer to live. He suddenly recognises that he has made a mess of his life. And especially this insight helps him to grow beyond himself, so that he is able to flood his apparently meaningless life with meaning. Mr Mitchell was the last man who died in the gas chambers of S. Quentin. Freedom is not the last word. Freedom is in danger of becoming arbitrariness unless it is lived in responsible-ness. And now you might understand why I so often recommend to my American students to supplement their Statue of Liberty with a Statue of Responsibility (Frankl, 2004, pp. 113-114; translation by the first author; see also www.sorfoundation.org).

Exercise: When making your next choice, try to imagine living your life again and being able to make amends (see Logotherapy’s categorical imperative above; see also the saying: Today is the first day of the rest of your life!). Reflect on any subsequent changes in your Reflective Journal.

Satisfaction with Life:
Description: Life satisfaction has been an important construct in Psychology, especially Health Psychology, as outward impairments do not necessarily reflect impaired sense of life satisfaction. There can even be an inverse correlation between the outward “good life” and life satisfaction, as seen e.g. by the young woman, who was pleased that she was suffering in camp as it had helped her realise much greater metaphysical depths (Frankl, 1985, p. 90).
Background: Logotherapy teaches that positive outcomes for the Self such as Happiness* and Satisfaction with Life can be achieved by Self-Transcendence*. Thus, working towards Goals* which satisfy creative, experiential and attitudinal Values* help the person overcome their ruminations and transform the previous sufferer into a helper. Self-worth is re-instated and Coping* sets in.

Positive Psychology's approach to Satisfaction with Life is more direct, trying to achieve life satisfaction by teaching people to be more like satisfied people, "...characteristics such as being organized, keeping busy, spending more time socializing, developing a positive outlook, and working on a healthy personality" (Diener, Lucas & Oishi, 2005, p. 69). This has been a promising pathway, too.

Evidence-Base: In addition to the above study showing positive outcomes, evidence for Optimism* enhancement programmes show that children can be taught more positive thought processes and Resilience*. The Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985), a 5-item self-report measure with good reliability and validity (see Nassar, 2008b for a review), has been used to find correlates of Satisfaction with Life such as higher purpose in life (PIL, see Meaning in Life*). An inverse relationship to Suicidal Ideation* has also been reported (see Nassar, 2008b).

Example: “Oh yes, I don’t believe in sitting down and doing nothing [laughs], mainly because out at [the aged care facility] there was a man living there...he had an accident at work and lost a leg and he could walk around and dance and do everything ... and this fellow sort of inspired me, you know [laughs].” (MacKinlay, 2006, p. 172).

Exercise: Please complete the following scale. Consider when it may be helpful using it with your clients:

“Please use one of the following numbers from 1 to 7 to indicate how much you agree or disagree with the following statements.

7 Strongly agree
6 Agree
5 Slightly agree
4 Neither agree nor disagree
3 Slightly disagree
2 Disagree
1 Strongly disagree

1._____In most ways my life is close to my ideal.
2._____The conditions of my life are excellent.
3._____I am satisfied with my life.
4._____So far I have gotten the important things I want in my life.
5._____If I could live my life over, I would change almost nothing.” (Lucas, Diener, & Larsen, 2003, p. 215).

Note: Calculate a total score. These range from 5 to 35, with 21-25 being the norm (see Diener, Lucas & Oishi, 2005).

Schizophrenia:
Description: Schizophrenia is a psychotic disorder characterised by distorted thinking, feeling and behaviour (e.g. Kuipers, Peters, & Bebbington, 2006).

Background: DSM-IV-TR criteria for Schizophrenia are:
“A. Characteristic symptoms. Two or more of the following, each present for a significant
portion of a 1-month period (or less if successfully treated):
1. delusions
2. hallucinations
3. disorganised speech (e.g. frequent derailment or incoherence)
4. grossly disorganised or catatonic behaviour
5. negative symptoms, affect flattening, alogia or avolition

Only one criterion A symptom required if delusions are bizarre or hallucinations consist of a
voice keeping up a running commentary on the person’s behaviour or thoughts or two or more
voices conversing with each other

B. Social/occupational dysfunction. For a significant portion of the time since the onset of the
disturbance, one or more major areas of functioning such as work, interpersonal relations, or
markedly below the level achieved prior to the onset or with children a failure to achieve the
expected level of interpersonal, academic or occupational achievement.
C. Duration. Continuous signs of the disturbance persist for at least 6 months.
D. Not due to schizoaffective or mood disorder
E. If there is autism or a pervasive developmental disorder, then prominent delusions and
hallucinations of 1 month’s duration must be present” (from Kuipers, Peters & Bebbington,
2006).

“Logotherapy … has to guide … the patient to objectify the illness and distance oneself from
it… and … to personalise the psychosis.” (Frankl, 1999, p. 61; translation by the first author).
This means that patients learn to laugh at their symptoms and not to take them too serious, and
on the other hand, to make them more personal, e.g. integrating them into their value and belief
systems such as seeing their condition as a test to be withstood and overcome (Frankl, 1999).

Evidence Base: SCP has found strong research support for Social Skills Training, CBT,
Assertive Community Treatment, Family Psychoeducation, Supported Employment, Socia
Learning/Token Economy Programs, and Cognitive Remediation. They found modest support
for Cognitive Adaptation Training and Illness Management & Recovery.
NICE guidance suggests:

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia sufferers must receive a comprehensive multidisciplinary assessment, including psychiatric, psychological, and physical health, with secondary addressing of accommodation, culture and ethnicity, economic status, occupation and education, prescribed and non-prescribed drug history, quality of life, responsibility of children, risk of harm to self and others, sexual health, social networks.</td>
<td>Offer CBT to all people with Schizophrenia. Offer family intervention to families of people with Schizophrenia living with or in close contact with the service user. Considering offering art therapies particularly to help alleviate the negative symptoms of Schizophrenia. Deliver CBT on a one-to-one basis over at least 16 planned sessions, establishing links between their thoughts, feelings or actions and their current or past symptoms, and/or functioning. Re-evaluation of people’s perceptions, beliefs or reasoning relates to the target symptoms.</td>
</tr>
</tbody>
</table>
Routinely monitor for coexisting conditions, including depression and anxiety, particularly in the early phases of treatment. Before a treatment can be implemented, ensure that service users are informed about patient-specific information about schizophrenia and its management in the appropriate format, to ensure informed consent. Apply the principles of the Mental Capacity Act when required.

CBT should include at least one of the following components: people monitoring their own thoughts, feelings or behaviours with respect to their symptoms, promoting alternative ways of coping with the target symptom, reducing stress and improving functioning.

Family intervention should include the service user if practical, with at least ten planned sessions over a period of three months to a year, taking into account preference for single-family intervention rather than multi-family group intervention.

Art therapies should help people to: experience themselves differently and develop new ways of relating to others. Express themselves and organise their experience into a satisfying aesthetic form. Accept and understand feelings that may have emerged during the creative process at their own pace.

Integrating the positive and meaning dimensions into the above treatment packages may take the form of acknowledging and empathising with the difficulties the clients find themselves in, helping them to differentiate between their symptoms and their inner core which is unaffected (see entry for Person* above). Highlighting Strengths* (such as Creativity*) will be beneficial. 

**Example:** Frankl (1999) describes a patient with delusions whose jealousy did not lead him to any aggressive behaviour. To the contrary, he spoilt his suddenly ailing wife, thus acting out of Compassion*, a manifestation of his spiritual dimension, rather than the physiological or psycho-social ones (see Formulation* grid above).

**Exercise:** When seeing a client with Schizophrenia or in role play with a colleague, empathise with their suffering. Help the client utilise their degrees of freedom, which are always accessible, e.g. by using the Fate-Freedom Balance* exercise.

**Socratic Dialogue:**

**Description:** This technique elicits clients’ dormant Values* and meanings. This is done by adhering to the following rules (Mendez 2004):

a. Specific, open-ended questions aimed at stretching clients’ thinking further
b. Thinking (rather than feeling) oriented questions
c. Questions are future oriented, starting in the present or past
d. The aim is “to facilitate self-discovery (knowledge), choice (decisions), uniqueness (personal significance), responsibility, self-transcendence, clarify needs and values.” (Mendez 2004, p. 163)

**Background:** It was named after the Greek philosopher Socrates (470-399 BCE). He saw how his mother, a midwife, facilitated births. This inspired him to use this facilitative approach in teaching, i.e. not telling students what they need to know, but rather helping them work out the answers themselves. It is used in Logotherapy to help clients/patients discover the hidden meaning in events and situations.

**Evidence-Base:** Fabry, Sheikh, & Selman (2007) found considerable overlap between Socratic questioning and **Socratic Dialogue**. Its effectiveness has not (yet) been explored much (Padesky, 2009, personal communication) and is rather taken as a given. Thus, there is a need for research into the Socratic technique.

**Example:**

**Client:** I am a failure. I feel so bad about it.

**Therapist:** How would you feel in case you had been successful?

**Client:** Oh well, I don’t know. I would be grateful to Gcd – He is the One Who gives success.

**Therapist:** Only because Gcd willed it so were you successful, is that right?

**Client:** Yes, that’s right.

**Therapist:** Is it possible that failure is not part of His plan?

**Client:** Hm… I’m not sure... That makes me think... May be it was His will after all (smiles).

**Exercise:** Go through the self-discovery and meaning-enhancing questions below and develop your own answers. Please note them down in your Reflective Journal for future reference. In case of difficulty, imagine what a close friend or relative of yours would say if they were asked these questions about you:

(a) “What are some of your greatest strengths?” “When was a time that someone expected the very best of you?”

(b) “What are two things you may do in the future that as of yet you have not done?” “What was a time when you put off something you should have done right away?”

(c) “What was it like for you when someone did not accept your point of view?” “What would you say were key turning points in your life?”

(d) “What was one thing you forced yourself to do and it was good afterwards?” “What are some things you want to learn in the future?” “Name something that you finished that you had a hard time starting.”

(e) “When was a time when you put energy into something you believed in?” “When was a time that you were of real help to someone in difficulty?”

(f) “What are three things that someone else wants you to be?” “What are two things that are difficult for you to accept?” (Wilson, 1995, cited in Mendez 2004, p. 164).

**Spirit:**

**Description:** It is the typical human capacity to rise above any givens, the hidden strength in every human being, such as “love, hope, gratitude, forgiveness, joy, future-mindedness, humility, courage, and noble purpose” (Templeton, 2005, p. VII).

**Background:** Spirit gives people the strength to show “conscious resistance against biological, psychological or sociological limitations” (Scholar, 2008, p. 103). Spiritual methods include a
phenomenological, client-centred approach (Ingram, 2006; Rogers, 1995), authentic encounter, being a fellow pilgrim, accepting no change as an option, philosophical discussions, honest feedback etc. (see Ingram, 2006).

“Why do we know so little about the human spirit? What enables us to override our biological inclinations to be selfish and instead find meaning, purpose, and value in nurturing and upholding the positive qualities of our human nature? … Love is more powerful than money; unlike money, the more love we give away, the more we have left.” (Templeton, 2005, p. VII).

“Logotherapy counts on the spiritual person, on the power of the spirit being able to take a stance against the psycho-physiological, to defy it. - Logotherapy counts on this <Defiant Power of the Human Spirit>; it refers to this power, it appeals to this power.” (Frankl, 1996, p. 148, translation by the author).

Frankl (2000) found that the human being is a non-linear being, so that circumstances cannot predict what the individual will actually do in any given situation. The Defiant Power of the Human Spirit or Resilience* is part of the human condition. It is the ability inherent in every human being to choose one’s stance toward whatever life situation one finds oneself in. It is the ability to live according to one’s human potential. Thus, Frankl did not let his own fears of flying hinder him and instead took flying lessons at an advanced age, becoming a passionate sports pilot.

Evidence-Base: Research into Resilience* shows, that human beings have the ability to withstand almost any traumatic experience, thus displaying the ‘Defiant Power of the Human Spirit’ (Frankl, 1999). Research into Spirituality shows: “Students who describe themselves as spiritual (or religious) are likely to report greater perceived health and greater perceived health likely influences life satisfaction for both men and women”. (Zullig, Ward, & Horn, 2006, p. 255; see also Satisfaction with Life*).

Example: A recovering alcoholic writes: “Some might think it odd when they hear an alcoholic in recovery say something like: “Being an alcoholic is the greatest thing that ever happened to me.” Perhaps they think that recovery is meant to only make us more like normal people, to catch us up. But we do not have the dubious luxury enjoyed by “normal people” who decide how and when to let G-d into their lives. Such is our fortune: that we must strive to join that happy lot for whom their very survival dictates that they give themselves entirely over to G-d.

We could never have planned it. G-d would never have advised it. But this is how things worked out. And this is what has made us closer to Him today” (Ben A., 2010).

Exercise: If you don’t do so routinely, practice assessing the spiritual dimension in role play with a colleague. A life time line might be helpful in depicting clients’ spiritual upbringing and how it developed from then on. What changed over the years? Was there a break with preconceived notions? How does the client perceive their spiritual dimension now? And what can I as therapist do to foster my clients’ sense of self with respect towards their spiritual growth?

Strengths:

Description: Pathology is the science or study of disease (Oxford English Dictionary, 2004), complimented by the science and study of Strengths, also called ‘forti’- and ‘salutogenesis’ (Struempfer, 2002). It is that, which enables human beings to stay and/or become healthy and resilient through focusing on what’s right, good and valuable.

Background: Logotherapy as well as Positive Psychology focus on supporting and improving this aspect of life. Fortunately, after a phase where the focus was on pathogenesis and
discovering the negative (Seligman, 2005), positive and protective factors as well as strength-based work (Kuyken, Padesky & Dudley, 2009) are being emphasised more and more in other approaches such as CBT and Systemic therapy.

To balance out the predominant problem focus, Peterson & Seligman developed the Character Strengths and Virtues (CSV) Handbook and Classification (Peterson & Seligman, 2004).

**Evidence-Base:** The CSV Character **Strengths** are underpinned by a growing evidence-base. Peterson & Seligman (2004) report findings such as smiles in college yearbooks predicting marital satisfaction later on, and increased life expectancy of people who have positive views of aging (Levy, Slade, Kunkel, & Kasl, 2002).

**Example:** “Jane, who was partially crushed after a passing car frightened the horse she was riding on... was suffering from chronic Post Traumatic Stress Disorder at the start of therapy. A month after completing a course of ‘Positive EMDR’ she came fourth in a riding competition.” (Blore, 2008, p. 1).

**Exercise:** Role play how to foster a strengths focus in your work with your clients. Reflecting on therapists’ self-talk will reveal where work needs to be done in fostering a strengths focus in therapists!

**Subjective Units of Satisfaction (SUS):**

**Description:** Wolpe (1985) introduced the Subjective Units of Distress (SUD) measure in psychotherapy, being still used widely. To compliment this pathological measure with a **Strengths** based tool, Fabry (2004) developed the **Subjective Units of Satisfaction**.

**Background:** Fabry (2004) developed this tool for her **Narrative Logotherapy** work. Using it in conjunction with the SUDs, this can form a major and invaluable part of Alternate **Assessment** (see example below).

**Evidence-Base:** SUD have been successfully employed in various research studies (Wolpe, 1985). There is anecdotal evidence for beneficial use of SUSs (Fabry, 2004).

**Example:** A person with an alcohol problem was sent to see the clinician. He did not think this was his problem, and rather saw his wife’s ‘nagging’ as the problem. Using SUSs across his lifespan as well as estimated units of alcohol consumption per week and estimated state of marital satisfaction, this revealed that alcohol consumption and marital satisfaction were in an inverse relation. SUSs very much followed the ups and downs of his relationship with his wife. This helped in the process of accepting **Respons-ability** for his otherwise externalising/blaming attitude.

**Exercise:** Create your own/clients’ life line of SUSs as well as SUDs, specifying what the cause for satisfaction and distress were at various points in life. In which way does this help you/your clients see things clearer? Which areas need enhancing?

**Suicidal Ideation:**

**Description:** **Suicidal Ideation** is the wish to die due to feelings of hopelessness.  

**Background:** This is part of Logotherapy’s **Neurotic Triad**. The Defiant Power of the Human **Spirit** helps clients overcome this hopelessness and despair. “There is nothing conceivable which would so condition a man as to leave him without the slightest freedom. Therefore, a residue of freedom, however limited it may be, is left to man in neurotic and even psychotic cases. Indeed, the innermost core of the patient’s personality is not even touched by psychosis.
An incurably psychotic individual may lose his usefulness but yet retain the dignity of a human being. This is my psychiatric credo. Without it, I should not think it worthwhile to be a psychiatrist. For whose sake? Just for the sake of a damaged brain machine which cannot be repaired? If the patient were not definitely more, euthanasia would be justified.” (Frankl, 1985, p. 156). Thus, therapists help clients perceive and utilise their degrees of freedom through methods such as Socratic Dialogue*

Evidence-Base: SCP has not yet provided guidance on this area.

NICE guidance on self-harm suggests:

Table 10: Summary of NICE Guidelines (2004) for Self Harm

<table>
<thead>
<tr>
<th>General Principles</th>
<th>Treatment</th>
<th>Psychosocial assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always treat people with care and respect. Ensure privacy for the service user.</td>
<td>Offer psychosocial assessment at triage to determine the following:</td>
<td>Assess needs and risk as part of the therapeutic process to understand and engage the</td>
</tr>
<tr>
<td>Take full account of the likely distress associated with self-harm. Offer the</td>
<td>mental capacity, willingness to remain for further psychosocial assessment,</td>
<td>service user. Consider integrating needs and risk assessment. Record assessment in the</td>
</tr>
<tr>
<td>choice of male or female staff for assessment and treatment. Always ask the</td>
<td>presence of mental illness. If a person wishes to leave before a</td>
<td>service users notes. Share written assessment with the service user. If there is a</td>
</tr>
<tr>
<td>service user to explain in their own words why they have self-harmed. Don’t</td>
<td>psychosocial assessment, assess for mental capacity/mental illness and</td>
<td>disagreement, consider offering the service user the opportunity to write this in the</td>
</tr>
<tr>
<td>assume it’s done for the same if witnessed on several occasions. Involve the</td>
<td>record assessment in the notes.</td>
<td>notes. Pass assessment on to the service user’s GP and to any relevant mental health</td>
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<tr>
<td>service user in clinical decision-making.</td>
<td></td>
<td>services to enable follow up.</td>
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By focusing on Strengths*, therapists can help clients realise their potential and utilise tried, but forgotten coping strategies (see also research into Resilience*).

Example: Frankl was asked to see a 60-year-old man with schizophrenia. This patient had auditory hallucinations and autism. He tore up papers all day long. “And nevertheless: What a strange, peculiar charm exudes from this human being, from the core of his humanity which has been untouched by his psychosis: Standing in front of us is a grand seigneur! From the conversation we learn that he sometimes flares up in a blind rage, but can hold himself back at the last moment. Then it happens that I ask him: ” For whom do you hold yourself back?” And he answers: ” For G-d....” And then Kierkegaard’s words come to mind: ” Even if insanity would hold the fool’s dress in front of my eyes – I can save my soul: When my love to G-d is victorious within me.” (Frankl, 2004, p. 105). A greater cause, whatever it may be, can empower the human being to overcome lower level urges and grow beyond them.
Exercise: Using generic therapeutic skills such as empathy, warmth, unconditional regard and genuineness (see also Rogers, 1951), elicit the wishes and aims of a client with Suicidal Ideation. Once these are established, use Socratic Dialogue* to elicit other ways of attaining these aims, or help the client reframe.

Tragic Triad:
Description: The notion that life is tragic in three main ways: pain, Guilt* and death (Frankl, 1985, p. 161).
Background: By experiencing the tragedy of life in his own situation, Frankl (1985) saw how pain, guilt and death are major challenges for human beings.

He asserted, however, that every human being is able to stand up against the threat inherent in these life events, thus overcoming them and growing in the process. He was fond of citing Nietzsche’s adage: “That which does not kill you makes you stronger”. How? The clinician helps the client take a stand towards the situation, e.g.
(1) ‘turning suffering into a human achievement and accomplishment’,
(2) ‘deriving from guilt the opportunity to change oneself for the better’, and
(3) ‘deriving from life’s transitoriness an incentive to take responsible action’ (Frankl, 1985, p. 162)

Dereflection* can help bring this point home by focusing on valuable aspects of the crisis (Fabry & Lukas, 1995) such as gained insight in what is important in life; friends, neighbours and colleagues becoming more caring and helpful; or enhanced empathy with others; following events such as:
(1) a painful event such as a miscarriage
(2) an event that the client feels guilty about such as having hurt someone’s feelings
(3) a situation which confronted the client with his transitoriness/death, e.g. one’s parents died.

Evidence-Base: See evidence for Dereflection*.
Example: “Alison was involved in a horrific car crash and became depressed because she could see no end to her suffering. Once again EMDR treatment cleared her symptoms, she now runs a very successful company rehabilitating drivers back to driving, her biggest client these days is the insurance company she originally claimed compensation from.” (Blore, 2008, p. 1).

Exercise: Combine the Tragic Triad with the Triad of Love, Hope* and Meaning in Life (Maas, 2002; Lapide, 2005). You derive a star. Make it shine by transcending its components as suggested by Frankl (1985, see above) and by living the positive Triad of your signature Strengths* for the benefit of mankind.
Transformation:
Description: Also known as reframing (see CBT literature such as Beck, 1995), Transformation entails changing one’s perception. This is done by cognitive techniques such as Derefection*, Attitudinal Change* and Humour*, e.g. in Paradoxical Intention*.
Background: Frankl’s notion of Transformation is important as it entails using what clients bring no matter how gloomy the outlook may be initially, and creating something beautiful from it (see Fabry, 2005).Transforming Tragedy into Triumph is a task Frankl lived and taught his clients to do. He thereby showed that tragedy is only as strong and devastating as the victim allows it to be (Janoff-Bulman & Frantz, 1997). By overcoming the urge to self-pity and focusing on others (Lantz, 2000), this Transformation strengthens the person as it changes the client from a victim and sufferer into a carer and provider for others – from a position of weakness into a position of strength.
Evidence-Base: Power & Brewin (1997) show how the Transformation of meaning is essential to successful psychological therapy no matter which approach is being utilised.
Example: Pattakos describes a two-day training session. He conducted the Ten Positive Things exercise (see Work*), but one participant, Paul, remained reserved.

The next morning... I noticed Paul sitting beside two ... participants, laughing and giggling. When I asked him what had happened, he reported, that when he went home the evening after our session, he was shocked to learn that his teenage daughter had received a tongue piercing and was now sporting a new piece of jewellery in her mouth! Angry and upset, Paul argued with his daughter and wife; in short, he had a terrible night with his family. When he returned to the training session the next day, looking tired and depressed, he confessed to his two ... co-workers what had happened. Immediately, they asked him to list the Ten Positive Things from his daughter’s tongue piercing! Working together, they not only came up with potential positives to be gained from his stressful experience, but also fostered an entirely new (and positive) attitude toward his daughter and the training session! Indeed, things could have been worse for his teenage daughter – doing this exercise put his situation in perspective for Paul and ultimately helped him change his attitude about it. (Pattakos, 2004, pp. 53-54)

Exercise: Attempt this exercise for PPD purposes, noting your reflections in your Reflective Journal!

Begin by jotting on a piece of paper the situation, problem, or predicament you are facing. Now, list analogous situations to yours, while making sure that you stretch your imagination as much as possible by deferring judgment. Enjoy the process of free association and making connections in your mind. Remember, you are trying to get away from you problem situation, so identify some situations that are varied and different from each other. As a catalyst and guide, go ahead and fill in the blanks of the following sentence: “My problem situation, (what is it?), is like (what is analogous to my problem situation?).” For example, “The challenge of having to merge two different organizations” is like “getting married.” (Pattakos, 2004, p. 139).

Values:
Description: Values are the issues that are important to us. “They are deeply held beliefs that we usually internalise during upbringing, or decide on as we grow older” (Boniwell, 2006, p. 49).
Background: Logotherapy places particular emphasis on Values (see e.g. Frankl, 1985; Graber, 2004; Mendez, 2004), as they help clients express their core motives. Thus, creative, experiential
and attitudinal Values pull the person into a desired direction away from Hyperreflection* on problems and towards a more healthy focus on Goals*. Clients achieve a Strengths* focus which helps them overcome their difficulties in an unobtrusive way. Driving away the darkness of a problem-focused life by lighting the candle of Values and Goals* is what Positive Psychology as well as Logotherapy have set out to do. Dereflection* can help clients detect Values as the very things they will report on as being valuable are those they deem to be important (a.k.a. the "big rocks" in the example below).

Evidence-Base: General satisfaction and Values are related to each other, thus showing the importance of examining one's Values (for a summary, see Sagiv, Roccas, & Hazan, 2004).

Example:

“Greg had the opportunity to attend a one-day workshop on time management. The leader of the workshop was speaking to a group of school administrators and, to drive home a point, used the following illustration:

As he stood in front of the group of high-powered overachievers, he said, “Okay, time for a quiz.” Then he pulled out a one-gallon, wide-mouthed mason jar and set it on the table in front of him. Then he produced about a dozen fist-sized rocks and carefully placed them, one by one, into the jar. When the jar was filled to the top and no more rocks would fit inside, he asked, “Is this jar full?”

Everyone in the class said, “Yes.” Then he said, “Really?” He reached under the table and pulled out a bucket of gravel. Then he dumped some gravel in and shook the jar, causing pieces of gravel to work themselves down into the space between the big rocks. Then he asked the group once more, “Is the jar full?” By this time the class was on to him.

“Probably not,” one of them answered, “Good!” he replied. He reached under the table and brought out a bucket of sand. He dumped the sand in the jar and it went into all of the spaces left between the rocks and the gravel. Once more he asked the question, “Is this jar full?” “No!” the class shouted. Once again he said, “Good.”

Then he grabbed a pitcher of water and began to pour it in until the jar was filled to the brim. Then he looked at the class and asked, “What is the point of this illustration?”

One eager beaver raised his hand and said “The point is, no matter how full your schedule is, if you try really hard you can always fit some more things in it!” “No,” the speaker replied. “That’s not the point. The truth this illustration teaches us is: If you don’t put the big rocks in first, you’ll never get them in at all. What are the big rocks in your life? Your children? Loved ones? Your education? Your dreams? A worthy cause? Teaching or mentoring others? Doing things that you love? Time for yourself? Your health? Your significant other? Remember to put these big rocks in first or you’ll never get them in at all. What are the big rocks in your life? How do you make time for them? What are the big rocks in your life? Place those in your jar first.” (Cantrell & Cantrell, 2005, pp. 138-139)

Exercise: Having read the above example, answer the question of the big rocks for yourself and/or share the example with your clients in an attempt to explore their Values.

Work:

Description: People spend a great part of their waking time at Work, which makes this an area that needs to be included in any discussion on affecting positive changes.

Background: Pattakos (2004) has shown how to successfully employ logotherapeutic principles to improve satisfaction at Work. Many companies embrace Corporate Responsibility (CR) of
some kind (such as social, environmental, etc., see Moore, 2008) as a starting point to help them
develop employee job satisfaction through enhancing the meaning perception of their staff.
Exercises such as ten positive things (see exercise below) or writing one’s own Eulogy help
focus on the main tasks in work and life, and what one wishes to be remembered for.
Evidence-Base: Evidence shows how positive Work experiences affect general mood,
interpersonal and marital relationships etc (for a summary see Turner, Barling & Zacharatos,
2005).
Example:

Tom ... had been let go by a high-tech firm after many years of faithful service. Although Tom clearly did not agree with the company’s decision to release him, and he felt that his value was neither acknowledged nor fully understood, he realized that he was given no choice but to move on with life. Ironically, Tom had discussed leaving the company many times in the past, but could not bring himself to make the decision to leave on his own. And while he felt positive about his chances for a new position or new work, he was unable to visualize the possibilities...

Forced to take a leap, Tom, by changing his attitude about his freedom, was able to change his attitude about his future. He is now combining several opportunities that more deeply reflect his passion, values, and interests. Ironically, it took the company’s decision to let him go before he was able to see the possibility of realizing his meaning potential... (Pattakos, 2004, pp. 47-48)

Exercise:

...think of a situation at work or in your personal life that is or was especially stressful, negative, or challenging. Now, take a deep breath, and write down ten positive things that could result – or did result – from this situation. Notice any resistance you may have to doing this. (Sometimes it’s easier to stay mad, or self-righteous, or right) But just let your mind loose and entertain the possibilities. Write down what first comes to mind. Continue to stretch your imagination and suspend judgment, listing whatever comes into your consciousness, no matter how silly, far out, or unrealistic your thoughts may appear to be. Feel completely free to determine or define what “positive” means to you. After you have completed your list, look at it closely, and let the positive become possible in your frame of reference regarding the difficult situation. Sometimes this is very hard to do. It requires a letting go of old ways of thinking, pain, remorse, disappointment, frustration, perhaps even grief and anguish. But it levels your playing field of possibilities for the future. Experience has shown that this exercise opens you to deep optimism no matter how challenging your circumstances.

The first time I was introduced to this exercise, I ... thought the exercise totally absurd... In fact, the participants had a great deal of fun...From the perspective of work, here now are some questions that have been posed in a number of settings:

1 “List ten positive things that would happen if you lost your job today. ”
2 “List ten positive things that would happen if your department was eliminated today. ”
3 “List ten positive things that would happen from a 20% budget cut.”


Worry:
Description: “If there is a worry in a man’s heart, he should suppress it. Let him find a good
thing and turn it into gladness” (Psalms, 12:25). This being true for rumination (Nolen-Hoeksma, 2000), a different type of **Worry** with positive consequences has also been described.

**Background:** Micro- (about oneself and one’s close family and friends) and Macro-**Worry** (about more global and contextual issues) have been described. The latter type of **Worry** has been found to enhance well-being in contrast to the former one (Schwartz, Sagiv, & Boehnke, 2000). “Worrying is actually good for you, as long as it is not self-centred” (Boniwell, 2006, p. 50). The Micro-**Worry** about oneself and one’s close family and friends leads to low quality of life and poor well-being (Nolen-Hoeksma, 2000). “Don’t ask but offer; make yourself needed, and you will fulfil your own needs, because the real basis of our need for others is our need to be needed by others” (Crumbaugh, 1973, p. 102).

**Evidence-Base:** There is evidence that **Worry** about others rather than oneself enhances well-being (Schwartz, Sagiv, & Boehnke, 2000), while **Worry**/rumination about oneself decreases well-being (Nolen-Hoeksma, 2000).

**Example:** Lukas (1986a) was seeing a client who was worrying about her suffering. Lukas helped her realise that her well-being depended on worrying about others rather than herself: “If you received only little love you can compensate that by the love you give... Think where you are needed, what task has been waiting for someone like you.” The client then remembered: “There is something I did before I became ill...I collected used clothes and toys and sent them to orphanages in South America. If you knew how grateful these people over there are for any help! Yes, I’ll start again, I know the organizations, their addresses, my illness will not prevent me.” (Lukas, 1986, pp. 103-104).

**Exercise:** The Trash Can Exercise (Pattakos, 2004) helps in overcoming one’s personal worries by writing them down and throwing them into the bin, thus ‘letting go.’
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