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- Embodied Collaborative Inquiry: a Pragmatic Practice-Based Research Approach
- An Introduction to Eye Movement Desensitization and Reprocessing (EMDR)
- Pluralism: An ethical commitment to dialogue and collaboration
- A Simulated Interview with Viktor Frankl: Part 3 - The Process of Psychotherapy

A Diversity of Views

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Contacting IJCP:

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From the Editor:

Dear Colleagues

Welcome to the autumn edition of the IJCP which brings an eclectic mix of subject matter including, fittingly, a paper on Pluralism. A definition of Pluralism is: 'a condition or system in which two or more states, groups, principles, sources of authority, etc., coexist. The topic of pluralism is perhaps familiar from the writings of Mick Cooper and John McLeod. In psychotherapy, the term refers to an assumption that client difficulties may have many interacting causes and, as such, an eclectic blend of therapies may be necessary. I suspect that many of us therapists have been practicing pluralism long before hearing of the term.

In keeping with the theme, we also include the 3rd and final part of Professor Overholser's fascinating window on the thinking of Viktor Frankl. Many of us will have been deeply influenced by the centrality of meaning making in logotherapy, given its effectiveness under the most extreme of conditions in Man's Search for Meaning.

Purpose or meaning, of course, is not necessarily a purely individualistic pursuit, as we see in our article on Embodied Collaborative Inquiry. Meaning is created, in this case, through a method of questioning in collaboration with peers. A phenomenological type of openness and a Gestalt of awareness of all aspects of one's direct experience are the hallmarks of this approach. The adoption of such enquiry allows the possibility of bypassing one's filters and biases and perceiving new knowledge and understanding through fresh eyes.

On a different tack entirely, our article on EMDR looks at a well proven technique for working with trauma. EMDR seems to work directly on the neurology of the brain and can be both effective and brief as a treatment. Peter Nevin does point out that EMDR is used in the context of humanistic therapy, so it may be seen as supplementary to traditional methods rather than a radical alternative. Nonetheless, it is fascinating that such a simple procedure can have any effect at all.

Cóilín Ó Braonáin PhD
Chair of the IJCP Committee

Call for Articles and Letters to the Editor

The IJCP welcomes articles on all aspects of counselling and psychotherapy. Our practice is to accept work of various styles, including articles that are academic in nature, articles based primarily on therapist professional experience, and also papers from students. It is not necessary for all submissions to be of a particular type, length or style. The aim of the editorial committee is to produce a journal of a high standard while being open to all the varied interests within the IACP. Letters may be on any topic of interest to the field of counselling.

Practitioner Perspective

Embodied Collaborative Inquiry: a Pragmatic Practice-Based Research Approach

By Billy Desmond

Introduction

This paper illuminates the development of collaborative inquiry as a practice-based research approach that is embodied, field orientated, pragmatic and of use to humanistic psychotherapy practitioners. The embodied collaborative inquiry method advocates a democratic and co-operative approach in the co-constructing of knowledge and meaning that is of the lived body and embedded in an intersectional field.

My argument here is not to dismiss evidence-based or more positivist perspectives of mixed-method research per-se, but to caution us as to their suitability for humanistic, and in particular relational Gestalt and Integrative orientated-practitioners who value a participatory and more democratic I-Thou (Buber,1958) process of relating. I will illustrate this form of research with an example from a collaborative inquiry process of embodied group supervision that I as supervisor co-created with three supervisees.

New Paradigms for Practice-Based Research

Traditionally, in more positivist-orientated research, the researcher is constructed as 'expert' with hierarchical power in such territories as methodology, methods, knowledge and arbiter of meaning-making. The researcher develops a hypothesis and then investigates this by researching **on** people and there is a tendency to be invested in the dissemination of universal truths to others (Crocker, 2017), as is the case with evidence-based practice. These are rigorous quantitative research processes, which require significant funding and often inform national health policy and the types of psychological interventions supported. However, the participants of such research endeavours are generally not involved other than as data sources, even though an ethics of care is dutifully honoured. Outcome research, which has its uses, such as the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) is an example of this approach (Stevens, Stringfellow, Wakelin & Waring, 2011).

In such approaches, there is a

There is a focus on empiricism rather than on more aesthetic forms of knowing that humanistic psychotherapy practitioner researchers experience in their daily relational practice with clients

The process is demanding. It requires those involved to be committed to rigorously examining how she/he is contributing to the research situation and how they are being affected by each other.

separation between the observer and the observed. There is a focus on empiricism rather than on more aesthetic forms of knowing that humanistic psychotherapy practitioner researchers experience in their daily relational practice with clients. Aesthetic knowing is;

"…emergent (it is born at a given instant), ephemeral (it only lasts as long as a given experience), bodily (it is incarnate in the senses and in the resonance of the body') (Francesetti 2012, p. 6)",

Aesthetic knowing is also intersubjective as an emerging contact phenomenon between people. I am particularly concerned about evidence-based studies where experience becomes isolated from its context. While it may be idiographic, the full aesthetics of human experience are lost for the sake of clarity and communication (Yontef & Jacobs, 2014).

My contention is that embodied and collaborative practice-based humanistic psychotherapy research offers unique opportunities to co-inquire into the sacredness and unfolding beauty of person-person relationships. Thus, in the collaborative inquiry approach I am about to share with you, psychotherapy practitioner-researchers research ***with*** people, ***not on*** or ***to*** people. I consider this a radical return to the relationship as the foundation for healing and change in human encounters within our practice and as part of the research process.

Collaborative Inquiry as a Dialogical Researching Process

Collaborative inquiry is defined by relational concerns. It is an approach where researchers work "…openly, directly and collaboratively with the primary actors in their various fields of interest" (Reason 1988 p.3). So, what does it look like? Individuals with a particular interest convene as a research group. All persons irrespective of role have a sense of involvement and ownership of the research process, where the application of the learning is a dynamic process (Anderson, 2007), with the hope that it can be translated into practice. This method is available to all psychotherapy practitioners (whether formally researching or not), who are committed to enhancing the efficacy of their practice. A collaborative approach to inquiry offers the opportunity to inquire into the lived human experience where participants are not objects to be studied or researched on but fellow inquirers to inquire *with "…[where] one person is ongoingly and reciprocally in contact with others"* (Bloom, 2009, p.37).

For example, several of us met as a supervision group with a shared interest in exploring embodied ways of knowing to support understanding of the client-therapist relationship that was a core task of supervision. Our supervision group was the source of our inquiry. The group constituted of one supervisor (me) and three psychotherapist supervisees, (two women and one man). Whilst I as supervisor initiated the process, the research became shared as supervisees led and shaped the areas of interest for exploration. Our initial focus was on developing the necessary supports for the lived body to be more available for each of us as we worked together. We met fortnightly for three hours and then spent 20 minutes post supervision, critically reflecting on the work. The meeting was recorded, transcribed, and shared amongst all members to be 'analysed' in order to identify emerging themes and learning. Differentiation was welcomed in order to integrate a multiplicity of perspectives and to avoid oversimplification of phenomena.

Such co-inquiry is a relational and reflexive process and demands of each researcher that they engage in 'me-search,' because personal experience is integral to the inquiry. The process is demanding. It requires those involved to be committed to rigorously examining how she/he is contributing to the research situation and how they are being affected by each other. This is a radical departure from more traditional methods of qualitative research where the primary researcher remains the custodian of the process and the creator of what is constructed and conveyed as knowledge.

Primacy of The Lived Body is Integral to Embodied Collaborative Inquiry

More traditional forms of collaborative inquiry involve a number of interested parties who gather to explore through the 'act of observing' an area of shared interest that is related to *their practice.* The underlying assumption is a separation or distancing of the observer and observed. As contact is '…the simplest and first reality' (Perls

et al., 1951/1994, p.3), the foundation of experience is our lived body. The lived body is the sentient, animating, resonating and purposive whole person that touches and is touched by the environment, and is an expression of the here and now relational situation.

We developed a process of supporting our 'gathering' at the beginning of each supervision session that was somatically orientated. All members took time to scan their whole bodies, to heighten awareness of the here and now co-creating experience. Each member was invited to notice their quality of contacting with the environment and with each other, and notice what emerged. Participants shared their here-and –now experience with or without words. Some members moved, or made a gesture. Others may have used objects or manipulated materials e.g. drawing, Plasticine to present how s/he was.

Including the lived body as central to the research process beckons us to honour multiple ways of knowing that include the pre-reflective, pre-reflexive and pre-verbal, not just the 'act of observing'. Our bodies know the score (van der Kolk, 2014) and are not a thing but an event (Claxton, 2015) that is foundational to conceptual knowing. This moment-to-moment unfolding of experience is revealed in the movement-to-movement of our gestural actions with others. This can be noticed in the language of words as manifest in action verbs (Robine, 2011), and through the language of our bodies in the kinaesthetic resonance (Frank & LaBarre, 2011) that emerges of the co-creating relational research situation.

Humanistic psychotherapists may be well resourced for such co-inquiry. Often due to the relational orientation of training, humanistic psychotherapists have a capacity to begin with 'what is', the actuality of the present moment and track how experience unfolds 'between' people through our embodied responses. Discovery comes into existence through our embodied dialogue with others.

Each inquiry cycle, whether planned or emergent has three distinct and overlapping aspects, which require attention to foster rigor and relevance in the collaborative inquiry process.

How Can Practitioners Engage in Embodied Collaborative Inquiry?

An embodied collaborative inquiry approach is best represented as a series of interconnected cycles of inquiry in the form of a spiral (Figure 1). The spiral form suggests a dynamic process that is full of movement. The number

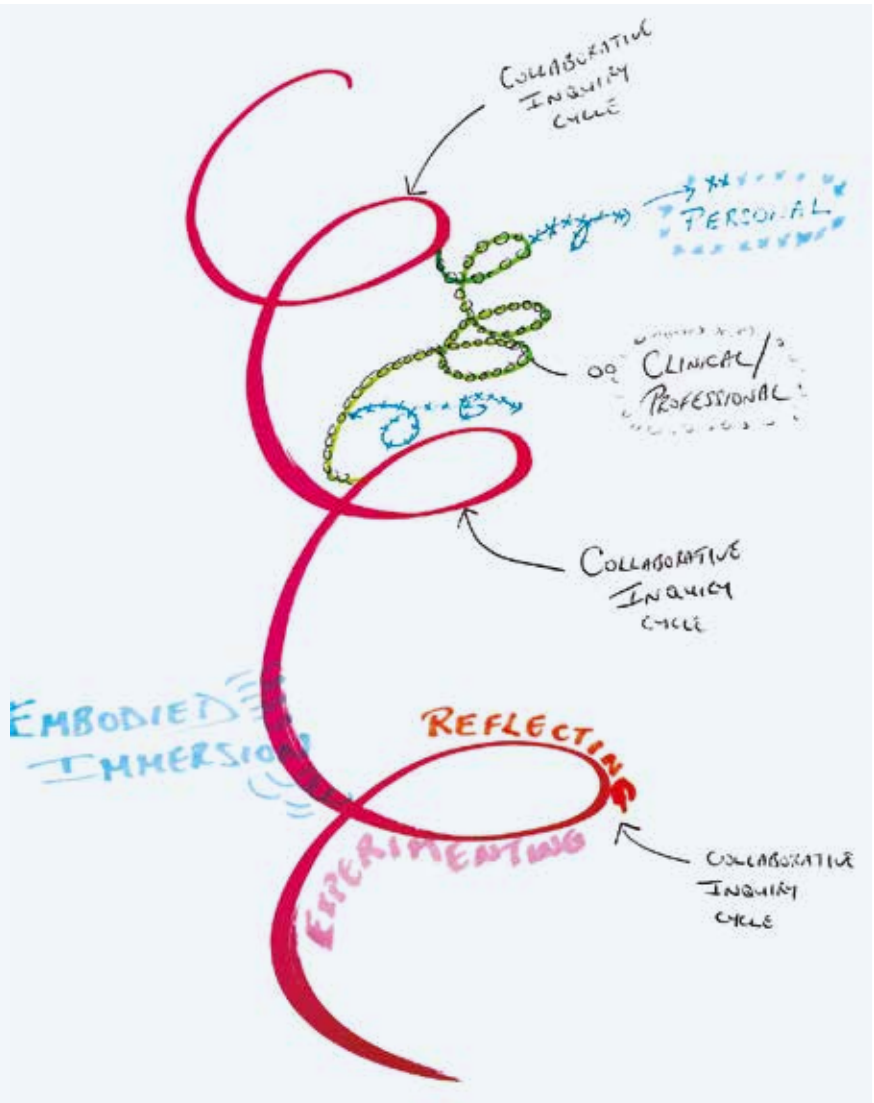

Figure 1: Cycles of Collaborative Inquiry

On the one hand we need to remain open to all that is visible and invisible... and simultaneously the pull is also towards honing and refining to create meaning and knowledge.

and duration of cycles required will depend on the constraints of time and resources as well as the complexity of the topic under investigation. Staying experience-near to the data as it emerges through the inquiry process often requires an updating and refining of the original planned cycles and their sequencing.

The way data is documented depends on the nature and focus of the inquiry. Data can be gathered through a variety of forms such as: audio and visual recording of work; transcribing content from recordings; reflective writing journals; visual and poetic representations; dance and movement; use of clay, Plasticine® and sand. Consent to participate or withdraw in a collaborative inquiry is a relational process and is revisited through dialogue between members at various stages of the research process.

This process of inquiry is an iterative one. Each cycle begins with an inquiry question generally framed as a 'what or how'. In collaborative inquiry every question has a clear intention to critically investigate an aspect of lived experience that is deemed relevant for the focus of research. As the research progresses each subsequent cycle is framed with an inquiry question that is shaped and informed by the learning from the previous cycle.
For instance, one of our initial cycles was framed as "how do we foster embodied awareness within group supervision?" As learning emerged each subsequent question framed a particular cycle of inquiry, for example; how is the heightening of embodied awareness affecting the work of group supervision? How does attending to the developmental moving patterns of the lived body, affect exploration of the client-therapist work?

In this process "inquiry is a continuous beginning" (Merleau Ponty, 1960/1964, p. 161) and each new cycle whether planned or emergent offers the opportunity to grasp, if only for a moment, a 'thick description' of the now, that throws a shadow towards the 'next'. Any interpretations and pre-mature meaning making is bracketed and placed aside. Such a process is one of distillation as the research focus is refined and supported by a disciplined phenomenological inquiry of the lived body and 'its' relationship to the wider field.

Phases Within an Inquiry Cycle

Each inquiry cycle, whether planned or emergent has three distinct and overlapping aspects, which require attention to foster rigor and relevance in the collaborative inquiry process. These aspects are: embodied immersion, critical reflecting/ reflexivity, and experimenting.

Embodied immersion within the here-and-now requires participants to "...plunge into the world instead of looking at it from the above" (Merleau-Ponty, 1968, p. 38-39). The here-and-now of the group and the question that orients the field of interest is fully fleshed, where "*affective feelings and tactile kinaesthetic feelings are experientially intertwined*" (Sheets-Johnstone, 2009, p.202, italics in original). Instead of leading prematurely with thinking, or finding the experiential evidence that confirms our sedimented assumptions, beliefs or constructs; we immersed ourselves in the now of our situation. As co-inquirers we committed to focusing attention to the lived body as if the skin boundary was open to movements of the experiential field.

We are seeking to discover and co-create supports for a particular inquiry cycle, which is framed by a specific question. The intent is yet to be realised in the immersion phase. This may seem paradoxical in a research activity. On the one hand we need to remain open to all that is visible and invisible as it is only then "are we able to contemplate and be informed by the unknown" (Barber, 2006, p. 66) and simultaneously the pull is also towards honing and refining to create meaning and knowledge. In this phase dwelling and trusting different ways of knowing beyond the cognitive, rational and worded allow us explore and develop different creative methods of inquiry that are locally emergent and experienced – near in relation to the focus of the inquiry within a specific cycle.

Critical reflecting and reflexivity occurs within the arc of embodied dialogue amongst group members. A critical reflectivity recalls the past practice to the present as a wholly embodied experience. This practice of reflectivity and reflexivity as an embodied inclusion may feel strange as it invites us to adopt

a hermeneutics of trust rather than suspicion or scepticism (Orange, 2011). This aspect of the inquiry is the ground of sense-making - an aesthetic endeavour when phenomena are described in multi-various ways beyond the rational, or language of experience with words. The group configuration of embodied collaborative inquiry holds each individual to account as they reflect-in-action and reflect-on-action. It insists that practitioners make a conscientious effort to "tell the truth about the making of the account" (Gergen & Gergen, 2000, p. 1028) to each other, and it includes multiplicity of experiences of self-in-relation and the forces of the wider field that the research is occurring within. Such a practice may be uncomfortable but it is fundamental in arriving at some knowledge with rigour and confidence, if only tentative and temporary.

During the supervision we engaged in a process of critically reflecting after each supervisory task to ascertain if heightening awareness of our embodied process was illuminating and of support to the supervisee and task being explored. Also, as we listened to tapes, reviewed the transcripts, our utterances and emerging movements or images were integrated as potential sources to facilitate meaning making and extract the learning for us all as co-inquiry participants of embodied group supervision.

Experimenting is also required to gather and give form to learning. Learning is garnered during an inquiry cycle by a willingness to surrender to each other, while remaining open to being irrevocably changed by

It is a dialogical approach that fosters a democratic orienting as all parties involved move between the parts and the whole- all the while honouring differentiation in the process of sense-making and meaning-making.

incorporating the multiplicity of perspectives shared. In an inquiry process this learning needs to be applied. There is no change without some movement happening. Otherwise it remains a theory beholden to the conjecture of those involved in the act of meaning making and may have little relevance for practice. Experimenting determines the relevance of any emerging research findings. We need to create the conditions to become adept in the practice of experimenting, knowing it can take a multiplicity of forms, occur over different time sequences (e.g. here and now, each session), and is emergent and co-constructed. Within collaborative inquiry, experimenting can occur in the group as well as in co-inquirers own lives and professional practice.

For example, a supervisee was invited to remember the therapeutic situation and immerse her/himself in the remembering of the co-created encounter, noticing any images, colours, smells, movements, and particular sounds/phrases. The supervisee was invited to constellate group members and objects in different parts of the room to reflect the therapeutic situation being explored. Group members were invited to pay attention to their bodily sensations, affect, feeling and movements. Next, I (the author) invited the supervisee to imagine him/herself as therapist in this co-created situation and sculpt the group by changing each person's posture or position in relation to each other to reflect the specific therapeutic situation/theme. The aim is to trust the knowing through the body

> "which precedes the intellectual working out and clarification of the meaning" (Merleau-Ponty, 1995/1962, p.185).

All group members were invited to pause and notice their kinaesthetic and affective sense in their bodies as they experienced the totality of this situation. Each person shared his/her experience first through a movement or gesture. After each person had moved the whole situation was once again attended and words in the form of 'I statements' were invited from each person to express what they now 'know' of this situation as an expression of the here and now relational field and there and now therapeutic situation. Once the process was completed all group members were invited to 'de-role', and reconvene as a group. Attending to the rhythm of the breathing and animating body in awareness supported this whole experience to be sensed and felt. Finally, the supervisee who was exploring her/his therapeutic work reflected on the process and articulated the meaning-making that she/he made for the on-going work with her/his client.

The process of experimentation allows practitioners the freedom to apply learning whilst always

remaining sensitive and aware of the intersectionality of situations, persons and their lived body experiences. And, it provides an opportunity to critique a discovery from the research activity in practice, as a way of demonstrating that any theory or meaning-making is contextualised and not a truth for all time and all moments.

Conclusion

An embodied collaborative inquiry approach has a utility for all participants involved, not only the researcher(s) and others in the scholarly field. It is a dialogical approach that fosters a democratic orienting as all parties involved move between the parts and the whole- all the while honouring differentiation in the process of sense-making and meaning-making. I believe such an approach to understanding the lived experience of human beings "...demystifies research and treats it as a form of learning that should be accessible to everyone interested in gaining a better understanding" (Bray, Lee, Smith & Yorks, 2000, p.3). Collaborative inquiry is messy, at times confusing and sometimes may feel overwhelming. Inquiry in this way is a lived body experience, and not hermetically sealed to the research situation only but embedded in a context that impresses upon all involved.

Sense-making occurs between people as a shared responsibility and requires a vulnerability of those involved to remain open to being changed during the inquiry process. In so doing we may "simultaneously challenge existing traditions of understanding, and offer new possibilities for action" (Gergen, 1999, p. 49). Such co-creating of knowledge and learning is always temporal, of given relational situations that are embedded in an interconnected mesh of phenomenal, social, professional, political and ecological fields.

Billy Desmond

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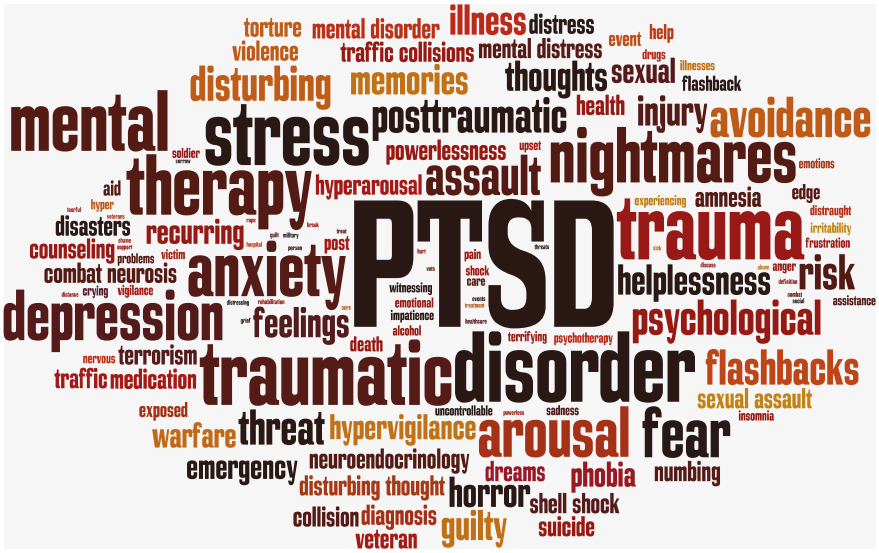
Practitioner Perspective

An Introduction to Eye Movement Desensitization and Reprocessing (EMDR)

By Peter Nevin



In theory, the body-mind can process and integrate information in a helpful way, but traumatic events interrupt this processing and leave the events in their 'raw', unprocessed state.

Introduction

EMDR is a therapy that has been shown to be very effective in working with people who have experienced severe trauma. It was first developed in the U.S. in the late 1980s by Francine Shapiro, a clinical psychologist, and is now recognised as a treatment of choice in working with adults with Post Traumatic Stress Disorder (PTSD). Over the past two decades or so, EMDR has also been used with clients experiencing a range of difficulties including anxiety, depression, childhood physical and sexual abuse and prolonged grief. However, EMDR is not a stand-alone therapy and is best used within on-going counselling or psychotherapy as an additional help for clients with specific processing difficulties and may be modified at times to suit the clients' needs.

'Alex (not his real name) was referred by his G.P. following a violent assault two months previously as he was making his way home from a night out with friends. He told me that he had been grabbed from behind by a man and dragged into a garden where he was violently assaulted and beaten around his head and face and had his phone and wallet stolen. A passer-by came to his aid and his attacker ran off. Alex told me that he could not remember much of the actual assault and that for him, the worst part of the experience was seeing the reaction of his family in the hospital when they first saw his injuries. He had a strong belief that he had let his family down. We used EMDR in two separate sessions and he was able to process the trauma in a very short period. Each session was around 90 minutes long. We arranged to meet for a check-in session six weeks later and he phoned to cancel it as he was feeling back to normal again.

How Does EMDR Work?

Interpreting and making sense of experiences in a flexible way are signs of good mental health. Conversely, the reduced ability 'to choose one's attitude' (Shapiro, 2002) in any situation is found in those people who present for therapy. A central concept in EMDR therapy is that we all have a physiological information-processing system that maintains an associated memory network and that it is our *ability to make appropriate connections* across these networks that ensures our mental well-being.

In theory, the body-mind can process and integrate information in a helpful way, but traumatic events interrupt this processing and leave the events in their 'raw', unprocessed state. This is perhaps why traumatised people seem to live with the traumatic experience *in the present*, while

Eye movements and other forms of Bilateral Stimulation (BLS) may help by 'distracting' the client sufficiently to enable the experience to be recalled so that processing can be completed.

nightmares, for example, may be the mind's attempt to process these experiences.

Traumatic experiences also cause us to develop mistaken *beliefs* about ourselves and the world around us, leading us to behave in ways that are unhelpful. Over time, these become fixed in the body-mind as irrational emotions, blocked energy and physical symptoms, complete with images, physical sensations, smells and sounds, and beliefs. According to Shapiro (2002), '… the individual reacts dysfunctionally to current situations because of automatic responses that were first elicited by past events and have become physiologically encoded.' The purpose of EMDR, like all psychological therapies, I believe, is to build or restore the client's freedom to choose their response in any given circumstance.

Often clients who have been traumatised say that it's too upsetting to even think about the event; eye movements and other forms of Bilateral Stimulation (BLS) may help by 'distracting' the client sufficiently to enable the experience to be recalled so that processing can be completed. This 'dual attention', the client focusing simultaneously on their internal world and on the BLS, allows the mind to process whatever it is noticing – 'one foot in the past and one foot in the present', so to speak.

What Happens in an EMDR Session?

In an EMDR session, the client is asked to focus on an image that represents the worst part of the traumatic event; next, the associated emotions of the worst part and then the location of the associated disturbance in their body. The client is also asked to describe both positive and negative beliefs about themselves associated with the worst part of the event. At this point, the therapist adds alternating eye movements or other form of bilateral stimulation (BLS), e.g., headphones, hand tapping, etc, for the client. If using eye movements, the therapist asks the client to sit in the chair in as relaxed a pose as possible, looking straight in front, with their feet flat on the floor and their hands and arms in a relaxed position on their thighs or on the arms of the chair. The therapist holds one hand with one or two fingers pointing upwards, in front of the client, finger tips at the client's eye level and about 50-60cms in front of the client. This means that the therapist is now sitting close to the client, usually to one side, with the two chairs facing in opposite directions. 'Ships that pass in the night', so to speak. It's important to consider how a client may feel about the therapist being so close and this can be explored in a discussion about EMDR in the first session.

Some clients - and therapists – prefer to use other methods of BLS. For example, I often use a small electronic box that emits a brief note or sound through a set of headphones that the client wears. A pair of small, pulsing hand-held devices can also be connected to this box and clients are free to undertake the work with their eyes closed or soft focused on the wall opposite. The headphones and pulsers are synchronised so that the client experiences a sound in the left headphone at the same time as feeling a pulse in the left pulser, and vice versa.

This bilateral stimulation enables *adaptive information- processing*, a 'rapid free association of information between memory networks that enables clients to draw on information where they find insight and understanding' (Parnell, 2007). Imagine you were given, say, a 100-piece jigsaw puzzle, without the picture of the finished puzzle. You might start with all the straight edges to form the outer frame. Then, very slowly at first, you would find where some pieces fit. As you proceed, you begin to get a sense of the picture. As you fit more pieces in, you are getting quicker and quicker at placing more pieces. Now, before it is finished, you know what it will look like. You have added new information to what you already knew and used this to have a more complete understanding of the finished picture.

Some clients process the material very quickly while others become stuck at certain points. I want to differentiate between the terms 'processing material quickly' and duration of therapy. Sometimes the client's self-reported level of distress can come down in a matter of minutes and this, in turn, means the client can access new ways of thinking about a specific part of the traumatic event. For example, if we are working on an experience where the client, as a child, witnessed an assault on one parent by the other, then the client's fear or anxiety can reduce in minutes and they are able, now as the adult, to understand that this was not their responsibility. However, this assault may be just one example from childhood that may also include the experience of being abused, neglected and abandoned themselves. In this case, the duration of therapy, with or without EMDR, could last many months. On the other hand, a client who has had a 'good enough' childhood and young adulthood, relatively trauma free and who experiences a traumatic event in adulthood, may 'process the

material quickly' within a session and require as few as three or four therapy sessions in total.

In situations where the client's processing gets stuck or the client begins to repeat the same material after two or three sets of BLS, the therapist can make interventions such as 'what could your adult self do to help you in that situation?' or 'do you remember another time when you felt like this?' or 'do you think that it's OK for a child to be treated this way?' These simple sentences, called *interweaves*, help the client to move through the material towards insight and understanding through the addition of new information for the client or to consider. Therefore, an interweave is an intervention that the therapist can make to assist the client in re-connecting with the processing of their emotions, thoughts or bodily sensations. (I often use the image of being a passenger on a train moving through the countryside, inviting the client to simply notice what is passing, just observing the images, feelings, sounds and so on). At the end of each set of BLS the client is asked 'what did you get there?' or 'what did you notice?' When the client describes, briefly, what they noticed, the therapist says 'go with that' for the next set of BLS. The session continues with sets of BLS during which the client continues to process disturbing information leading to a more balanced state where integration takes place.

EMDR transforms experiences that are emotionally charged and 'present', into memories that are more objective and remembered as events. One client said he remembers *how he used to feel* about a particularly distressing experience in his late teens, yet was able, after an EMDR session, to talk openly and calmly about the experience to his partner for the first time ever. Another client said 'it's like reading about it in the newspapers', while talking about her difficult childhood experiences.

How Many Sessions Will it Take?

The number of sessions depends upon the specific problem and the person's history. However, studies have shown that a single trauma in adulthood can be processed within three sessions of EMDR in 80-90% of people, given a 'good enough' childhood and young adulthood. While every disturbing event need not be processed, the amount of therapy will depend upon the complexity of the person's history.

Useful Resources

In the U.S., the Department of Veterans Affairs recommends EMDR as one of three therapies for the treatment of PTSD. https://www.ptsd.va.gov/public/treatment/therapy-med/treatment-ptsd.asp. For a brief U.S. TV video report on EMDR see the 'kcestarte' video on YouTube at http://www.youtube.com/watch?v=zBtqWrs2-K0.

Concerning the U.K., the National Health Service recommends EMDR for the treatment of adults with PTSD. https://www.nhs.uk/conditions/post-traumatic-stress-disorder-ptsd/ treatment/. Whereas in Ireland, EMDR is recommended by the HSE for the treatment of PTSD in adults; https://www.hse.ie/eng/health/az/p/post-traumatic-stress-disorder/. A listing of EMDR practitioners in Ireland can be found on http://emdrassociation.org.uk/ with therapists located in, for example, Donegal, Dublin, Waterford, Cork and Limerick.

Other websites which are useful for further information are: –

www.emdrassociation.org.uk.

www.nhs.uk/Conditions/Post-traumatic-stress-disorder/Pages/Treatment.aspx.

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Practitioner Perspective

Pluralism: An ethical commitment to dialogue and collaboration

By Dr. Marcella Finnerty, Ms. Caitríona Kearns & Mr. David O'Regan

Students, practitioners and patients, are confronted with confusion, fragmentation and discontent. With so many therapy systems claiming success, which theories should be studied, taught or bought?

(Prochaska & Norcross 2018, p.1).

The early history of psychotherapy and counselling is dominated by the development of different schools, each eager to present its case against the others and each with its own language, which only those committed to its ideas would be likely to understand. The resulting cacophony has been likened by Stanley Messer to the Tower of Babel (2012). A separatist, denominational spirit prevailed in which theory, mainly in the form of dogmatics and lacking any substantial research base, was propounded within an adversarial culture characterised as "dogma eat dogma" (Messer, 2012). Even for clinicians socialised strongly into a particular school of therapy, the failure of any one orientation to demonstrate universal success has been striking (Norcross & Goldfried, 2011). Arguably, in Ireland, the field remains fragmented. This is evidenced in recent position papers drafted by two of the main professional bodies, whereby one asserts that psychotherapy and counselling are distinct professions, with different levels of expertise and competency (ICP, 2015, p.1), while the other maintains there is "no proficiency difference between counselling/psychotherapy" (IACP, 2015, p.3). When there is conflict, we agree with the view that there are truths to be addressed on each side, which can only be resolved through dialogue. If that perspective is correct, perhaps a pluralistic approach, where dialogue is central, is a way of moving forward. Ultimately therapists need to be competent and comfortable with a variety of methods to face the challenges and privileges their role bestows.

Definition of Key Concepts

Pluralism as a philosophical concept speaks to the idea that multiple truths exist and that many things are helpful to different clients. Cooper and McLeod (2011, p.6) view this as "a way of practising, researching and thinking about therapy", which is all-embracing.

They define it as "a both/and" standpoint, arguing that there is value in the range of available therapeutic models. O'Hara and Schofield (2008) consider that pluralism is an approach to managing the tension created by the use of different theories. Adopting a pluralistic approach enables therapists to use a variety of theories, without the need to reconcile differences. The pluralistic view is predicated on a collaborative relationship between client and therapist, where the client is empowered as the expert in their own life. It is postmodernist insofar as truth is seen as constructed more so than discovered, and the central philosophical underpinning holds that "any substantial question admits of a variety of plausible but mutually conflicting responses" (Cooper & McLeod, 2007, p.137). Messer believes that unity in psychotherapy is not possible because we do not "simply discover what is inherent in nature…we invent our theories and categories and view nature through them… there is no single truth and, by extension, no one unified or integrated theory of therapy to discover" (2008, p. 364). This, therefore, leads to a pluralistic outlook both methodologically and theoretically. It is argued that all integration may be considered as an evolving, processual activity, as well as an implementation of specific integrative models (Oddli, & McLeod, 2017; Oddli & Rønnestad, 2012).

Polkinghorne suggests that the vast array of existing theories provides "prima-facie evidence that no one theory is correct" (1992, p.158). Moreover, he contends that universalising one's experience, as being generalizable to every client in every situation is, in effect, a therapeutic error. Cooper and McLeod (2011) maintain that pluralism in psychotherapy is an attempt to establish an approach that has the framework of a set of principles and meta-strategies, which can be easily adopted by therapists from different backgrounds. Pluralism is seen, therefore, as a way to overcome the limitations of other integrative approaches, while at the same time drawing on the most beneficial characteristics of these models. It does not ask anyone to abandon ideas and methods they find useful. It does, however, invite serious consideration of other options alongside the favoured and familiar. Furthermore, while pluralism is a philosophical concept, it can also be conceptualised as a particular way of engaging with clients:

> Pluralistic Therapy refers to a specific form of therapeutic practice that draws on methods from a range of therapeutic orientations, and which is characterised by dialogue and negotiation over the goals, tasks and methods of therapy (Cooper & McLeod, 2011, p.8).

A pluralistic stance is associated with a reflective and nuanced approach to the issue of how we know what is true. It implies that there are different types or sources of knowledge, each of which has its own validity. The concept of pluralism functions as a meta-perspective or meta-theory from which therapy theories as a whole can be examined for their relevance in any particular case (McLeod, 2017). Pluralism indicates a certain pragmatism: an effort to transcend dogmatic adherence to particular traditions or identities, and to draw on a wide theoretical base as appropriate, with the client at the heart of the process.

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Practical Application of Pluralistic Counselling and Psychotherapy

When applying this approach to practice, attunement to client goals is paramount for a number of reasons. Firstly, evidence suggests that 'goal consensus' is positively correlated with meaningful outcome (Tyron & Winograd, 2010). More importantly, Cooper and McLeod (2011, p.57) maintain that we can only truly begin collaborative work when we align ourselves to what the client wants. Therefore, the pluralistic framework aims to put the client at the heart of the therapeutic process and attempts to maximise the client's involvement by specifying a set of strategies for creatively drawing on several therapeutic practices and theories. Consequently, working with client goals is both a practice issue and an ethical one. Cooper and McLeod (2011, p.58) describe the focus on client goals in four ways:

- It implies that the client is an active agent, engaged in the process.
- It recognises the client as a separate person,

As therapy is very often not the first port of call for people seeking help, it can be assumed that clients have spent some time coping with their difficulties in other ways.

who possesses his own perspective.

- It involves a 'deliberate ethical stance', where informed consent is not just a nice idea, but rather intentional practice.

- It is 'a pragmatic strategy' for identifying the resources that the client holds.

Essentially, tasks are defined as "concrete, lower-order goals" (Cooper and McLeod 2007, p.138). Unlike the broader goal, say of 'I want to be confident', a task is action-orientated with the therapist and client collaboratively identifying specific steps to aid the client in attaining confidence. Hence, if the client's goal is to be confident, therapy should involve setting up a task that is likely to address that goal. When considering tasks, the steps proposed by Cooper and McLeod (2007, p. 138) involve:

- Agreeing what the task is;

- Carrying out the task; and

- Knowing when the task has been successfully completed.

Cooper and McLeod (2011, p.61) reason that working with tasks and goals is a 'privileging' of the client's perspective and, moreover, allows one to determine "whether the methods that the therapist can offer fit with this."

In their work, they describe 'methods' as "the actual procedures or actions that a therapist and client jointly perform" in order to achieve the tasks and goals (Cooper & McLeod, 2011, p.93). As collaboration is interwoven into every aspect of pluralism, the practitioner should not decide the selection of methods. Instead, it should emerge from dialogue and conversation with the client. It is incumbent on the therapist to be "willing and able to dismantle…theories in order to be able to identify methods that can be suggested to clients"; additionally, therapists are encouraged to "develop a repertoire of methods that can be offered" (Cooper & McLeod, 2011, p.115). This elicitation of goals, tasks and methods is not a one-off intervention. Instead, consistent attempts at collaboration, dialogue and communication are inherent to the approach.

Even though a central point of the pluralistic approach is focusing on client goals it does not forget the importance of being flexible and allowing for the here-and-now process of therapy. Clients do not generally arrive to therapy with a clear idea of what it is they want from therapy, only to feel better; therefore, initial goals can be vague. In fact, "many who present themselves for counselling are vague or uncertain about what the problem is" (Yeo, 1993, p.109).

Central to building a collaborative therapeutic relationship is metacommunication Cooper and McLeod describe metacommunication as a conversational strategy that refers to "moments in the conversation where the therapist (or the client) pauses to reflect on the way in which the topic is being discussed". In other words, it is communication about communication (2011, p.46). The pluralistic framework recognises the client's strengths and resources. As therapy is very often not the first port of call for people seeking help, it can be assumed that clients have spent some time coping with their difficulties in other ways. These resources can be either healthy or unhealthy. For example, clients may have used exercise, herbal remedies, friends or family to cope with issues. Similarly, clients may have used alcohol, drugs or other destructive behaviours as a way to survive. With these strengths and resources, comes the idea that the client may have some understanding as to the cause of their problems and can reflect on how using these strengths and resources might help in resolving their difficulties.

While considering clinical work, it is vital to acknowledge that the client will have cultural resources. Cultural resources can include, but are not limited to, spirituality, religion, diet, exercise, creative arts and community. Marley (2011) found that the predominant factor in limiting distress was accessing support from others; Batt-Rawden (2010) noted that participants of their study were helped by music to cope with a range of tasks, problems and symptoms. These studies, among others, imply that there are implications for practice within the pluralistic framework in that it can provide a client with

an array of possibilities (Cooper & McLeod, 2011). However, Sarris, O'Neil, Coulson, Schweitzer, & Berk (2014, p.8) state "some lifestyle choices and "vices" may provide the person self-perceived support and comfort, and in such cases change needs to be handled delicately."

Another important consideration in the pluralistic framework is client preference. According to McLeod (2012), there is a substantial body of evidence that the fulfilment of client preferences has a significant impact on whether a client will stay in therapy. Client preferences can be in relation to broad therapy approaches or a wide range of specific theraputic approaches (Cooper & McLeod, 2011). Being attuned to client preferences and understanding their individual requirements leads to good therapy, demonstrating respect and understanding for the client.

However, as with all aspects of the pluralistic approach, client preferences need to be collaborative, meaning there may be a divide between what the client wants and needs, and differences need to be negotiated. Receiving feedback from clients requires the therapist to remain open minded, and to be willing to share their ideas of the cause of the psychological distress with their client (Cooper & McLeod, 2011). An open-minded therapist will work collaboratively with clients to evaluate realistic goals for therapy.

A Critical Evaluation of Pluralistic Therapy

Underlying Principles

John Norcross maintains that there are some 400+ approaches to therapy. He contends, "rivalry among theoretical orientations has a long and undistinguished history in psychotherapy" although he asserts there has been a "decline in ideological struggle" in the past 20 years (Norcross, 2005, p.3). Perhaps this is the case in the USA, however, Cooper and McLeod (2011, p.1) claim orientation-based conceptualisation is still evident in proposals for "highly specific, manualised forms of therapeutic interventions" in the UK. Furthermore, in Ireland, it is evident in moves toward mandatory, manualised CBT training for nursing and clinical staff of the Health Service Executive's mental health and addiction services (HSE, 2012).

Perhaps the greatest weapon in the monist's armoury is the proliferation of Randomised Controlled Trials (RCTs) of particular therapeutic models.

Pluralism can be directly contrasted with monism (Cooper & McLeod, 2011). Rather than seeking the "one true meaning" (Strenger & Omer, 1992), pluralism allows that a myriad of approaches to "psychological distress and change may be "true"' (Cooper & McLeod, 2007, p.137). Additionally, the pluralistic approach proposes that it is useful to differentiate between "pluralism as a perspective" and "pluralism as a particular form of therapeutic practice", as even a single-school practitioner may be pluralistic in their perspective, and hold the belief "that there is no one, best set of therapeutic methods" (Cooper & McLeod, 2011, p.7). That said, the idea that someone might believe that there is no one truth, yet holds to monist practice, raises questions of congruence. If a therapist truly considers that a monist approach will not work for everyone, is there not an ethical obligation to expand one's practice?

According to Cooper and McLeod (2011, p.6), the pluralistic approach "starts from an assumption that different things are likely to help different people at different points of time." Furthermore, they argue that engaging clients in a dialogue about what they believe is likely to help them is a key tenet of pluralistic practice. When reviewing the approach, it is therefore important to examine the two fundamental principles (Cooper & McLeod, 2011, p.6) of pluralistic practice from a critical standpoint:

- There is no one truth. Many things can be helpful to clients; and
- If we want to know what is likely to help, we should talk to the client about it.

Multiple Truths in Psychotherapy?

Like McLeod and Cooper, Norcross (2005, p.5) speaks of a "growing awareness that no one approach is clinically adequate for all patients and situations." The argument for a pluralistic stance, philosophically, is not a new one, but it is useful to consider the counselling and psychotherapy related evidence for this principle.

Perhaps the greatest weapon in the monist's armoury is the proliferation of Randomised Controlled Trials (RCTs) of particular therapeutic models.

There is a large body of literature supporting the idea that clients who receive their preferred method of therapy do better in therapy and are less likely to drop out.

Persons (1998, p.127), in her arguments about the value of RCTs for therapists, proposes that clinical trials are "widely accepted…as the gold standard of evidence about treatment efficacy." She maintains that, when all else is equal, the evidence from an RCT can tell us which therapy is 'superior' to another. Arguably, when it comes to RCTs, one has to ask when exactly is 'all else' equal? By their very nature, RCTs are controlled, and as a result, arguments about generalizability are prolific (Shean, 2014; Clay, 2010; Leichsenring, 2009; Hunt, 2012). Moreover, converse to Persons' argument is a plethora of research suggesting that no model "has reliably demonstrated superiority over any other approach" (Duncan & Miller, 2005, p.4). Bruce Wampold (2011) further argues that the evidence for superior approaches is 'negligible' at best. In contrast, Cooper (2008, pp.53-54) reminds us that this "argument is not without its critics" and that it fails to take into account one of the main pluralistic principles, "that different clients may benefit from very different types of therapy."

While RCTs can espouse evidence that one model of therapy is, in general, more effective than another for a specific problem, methodological issues, such as sampling, must be considered. Shean (2014) reminds us that many RCT psychotherapy studies are limited to participants with a single diagnosis. He asserts that this "does not mirror the reality of most clinical practice" (p.2). In day-to-day practice, the exclusion criteria in RCTs, such as co-morbidity, may be very much present in our casework.

Even using the 'gold-standard', many RCTs fail to prove that one treatment is better than another. For instance, the Cannabis Youth Treatment Study randomly assigned some 600 cannabis-using youth to one of five different adolescent substance abuse treatment approaches. "Overall, the clinical outcomes were very similar" across the five sites (Dennis et al, 2002, p.197). Additionally, even in RCTs with high success rates, some clients do not improve. In reality, outcome research finds that approximately 5% to 10% of adults receiving therapy actually deteriorate. Furthermore, this statistic is evident in both clinical trials and routine practice research (Shimokawa, Lambert, & Smart, 2010; Hansen, Lambert & Forman, 2002). Consequently, even with the most 'successful' therapy in an RCT, there are clients who do not respond well, lending credence to the argument that clients may possess an "aptitude for certain interventions and a tendency to respond less well to other[s]" (McLeod, 2013, p.1).

The second key principle of Pluralistic Therapy relates to a commitment to engaging clients in dialogue and feedback about therapy, in particular regarding client preferences. This collaboration and communication with clients is evident in all aspects of pluralistic therapy, from discussions about therapy preferences, goals, tasks and methods, to the use of process and outcome measures as feedback tools.

Client Preferences and Feedback Tools

In his critique of Cooper and McLeod's literature, Richard House (2011), claims their work contains an "absence of considerations of power." This is portrayed as a 'silence', which seems incredible considering the texts he refers to contain multiple implicit and explicit messages related to dialogue, incorporation of client preferences, on-going meta-communication and the idea that the "therapist [should] be guided by the client's preferences and choice" (Cooper & McLeod, 2011, p.41). Arguably, at its very foundation, considerations of power are addressed in pluralistic therapy. The philosophical position and practical application of this approach is specifically geared towards creating a space in which power and choice is with the client. Furthermore, Cooper and McLeod (2011, p.35) clearly state,

> If it is the therapist alone who decides on which therapy interventions and theories to use, then the strengths, capabilities and preferences of the person seeking help are likely to be oppressed and silenced.

One clear way that Pluralistic Therapy demonstrates consideration of power issues is through the elicitation and utilisation of client preferences. There is a large body of literature supporting the idea that clients

who receive their preferred method of therapy do better in therapy and are less likely to drop out (Swift & Callahan, 2009; Swift, Callahan & Vollmer, 2011; Tomkins, Swift, & Callahan, 2013). For instance, Swift and Callahan claim, 'matched clients have a 58% chance' of better outcomes and are 50% less likely to drop out of therapy (2009, p.368). It is also important to reflect on potential implications when client preferences are not respected. Although citing a medical study on diabetes treatment, Torgerson and Sibbald's (1998, p.316) finding that "resentful demoralisation" occurs when patients do not obtain their preferred treatment may be of relevance to our field. Surely, in a profession that explicitly holds the ethical stance of "client autonomy" (BACP, 2015; IACP, 2015), it should be best practice to include client preference in our case planning?

Notably, not all research finds a positive correlation between outcome and incorporation of client preferences. In their study exploring therapy preference in clients with mild to moderate alcohol dependence, Adamson, Sellman and Dore (2005, p.210) cite Sterling et al., (1997) as an example of research that "found almost no difference in treatment retention or outcome." Furthermore, in their own research, Adamson et al., (2005, p.213) maintain, "there was no significant association between treatment preferences … and any of the treatment process or outcome measures." Interestingly, apart from a timeline follow-back procedure to assess drink-related outcome, the only outcome measure used in this study was the Global Assessment Scale; a clinician rated tool. Accordingly, one might argue that the 'outcome measures' used were limited and failed to consider the client's perspective. Furthermore, it must be noted that there is a distinct difference between offering someone a choice between two models of therapy and offering them their preferred type of therapy. Arguably, participants in either treatment group in Adamson's study may not have been receiving their preferred therapy at all.

Early research into therapist experiences of using the TPF noted that therapists found it a helpful way of identifying what clients want from therapy.

Cooper and McLeod (2011, p.24) suggest that examining "the relationship between clients' preferences" for different therapies and the effectiveness of those interventions' is vital. In pluralistic practice, incorporation of client preferences is not limited to offering clients choice between two (or more) distinct therapies. Certainly, the therapist will present the client with their therapy menu, but more than that, they will strive to identify specific things the client might want. So how is this achieved?

Tompkins, Swift and Callahan (2013, p.280) state that the easiest way to assess client preferences is "to directly ask … which therapy conditions they would prefer." Conversely, Cooper and McLeod (2011, p.5) argue, "even with such direct communication…it can still be difficult for clients to ask for what they want" and they suggest feedback forms as a helpful way of identifying preferences. Bowens and Cooper (2012) highlight a challenge in this, noting that most feedback tools are designed with outcome in mind, whereas client preferences are clearly in the realm of process feedback. As a result, Cooper & Bowens developed the Therapy Personalisation Form (TPF), which is designed to elicit "a fine-grained understanding of clients' preferences and wants for treatment" (Bowens & Cooper, 2012, p. 48). Early research into therapist experiences of using the TPF noted that therapists found it a helpful way of identifying what clients want from therapy.

On the other hand, in this study, a theme that emerged was the potential negative impact of increased therapist self-criticism and/or of therapists attempting to mould themselves too much, and, as a result, perhaps losing their natural way of being (Bowens & Cooper, 2012). Cooper and McLeod (2011) also suggest that it can be difficult to receive negative feedback from clients. What may be reassuring, when faced with this difficulty, is the "growing evidence that the process of responding to a client's negative feedback… can contribute to the strength of the therapeutic alliance" (Miller, 2012, p.30). As feedback and dialogue with clients about the process of therapy is such an important facet of pluralistic practice, it is useful to examine some of the evidence for this type of feedback. For instance, Miller and colleagues suggest,

> When a simple measure of alliance is used in conjunction with a standarized outcome

There is wider recognition of the view that there is no one truth, nor is there only one way of accessing possible solutions and insights.

> measure, available evidence shows clients are less likely to deteriorate, more likely to stay longer and twice as likely to achieve clinically significant change (Miller, Hubble & Duncan, 2008, p.21).

Miller et al., are not alone in their assertion that inclusion of measures improve outcome. Lambert & Vermeersh (2008) argue that therapists who use measures are better at identifying clients who are not improving or who are more likely to drop out of treatment and Bohanskey & Franczak (2010) found that utilisation of such measures reduced cancellation and no-show rates. Arguably, such findings support use of feedback and dialogue with clients. It is to be welcomed that developments in the field are promoting the generation of reciprocal linkages between practitioners and researchers to explore the use of integrative approaches, including pluralism, to improving mental health interventions (Fernández-Álvarez, Consoli, & Gómez, 2016).

Conclusion

A pluralistic framework for counselling and psychotherapy recognizes that psychological distress may have multiple causes and it is improbable that one specific therapeutic approach will be effective in all circumstances. There is also a growing recognition that therapy is rarely "pure-form" in practice or outcome, most therapists routinely incorporate a variety of methods traditionally associated with diverse systems into their practice, and the therapeutic relationship accounts for more treatment outcome than specific techniques (Geller, Norcross, & Orlinsky, 2005).

Returning to Gordon Paul's classic question in 1967 of what works for whom, it is fair to say that while little progress has been made in more than 45 years of searching, there is wider recognition of the view that there is no one truth, nor is there only one way of accessing possible solutions and insights. While a growing majority of therapists declare themselves integrative, the form this takes would seem to depend on the personal choice of the therapist. Pluralism aims to create dialogue between different modalities; hence it sets the scene for a strengthening and unifying of the profession in Ireland.

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Academic Article

A Simulated Interview with Viktor Frankl: Part 3 - The Process of Psychotherapy

By James C. Overholser, Ph.D., ABPP, Case Western Reserve University.

Introduction

The process of psychotherapy is changing in this age of evidence-based practice and structured manuals to guide treatments that have been designed to address specific problems. However, for many clients, existential views are important but neglected topics in their therapy sessions. The present manuscript explores logotherapy and the process of psychotherapy using a simulated interview derived from a series of Frankl's previously published remarks.

Contemporary psychotherapy is undergoing a major shift, with a heavy emphasis on evidence-based practice and treatment outcome research. Most of these treatments rely on structured treatment manuals to guide the therapy, and the interventions have been designed to confront specific symptoms of specific psychiatric disorders. However, many clients struggle with broader existential concerns that cannot be captured in a pre-planned manual.

In contrast, Viktor Frankl recommended a thoughtful approach to psychotherapy sessions that was uniquely adapted to each client and their particular concerns. The process relied on a series of provocative questions to help clients shift their perspective and improve their attitude. These notions will be explored using a simulated interview format.

In the age of cognitive-behavioral therapy and evidence-based practice, there is less interest in forms of psychotherapy that are based in philosophical foundations. Furthermore, as online sources and electronic journal articles replace the older journals that collect dust in the stacks of the libraries, the new generation of psychotherapists have often never read the original words that helped to shape the field of psychotherapy. There is a risk that the field could fail to hear the words and lose the impact of these pioneers. The present manuscript uses a simulated interview format to explore Frankl's views about psychotherapy process. What follows is the process of psychotherapy according to Viktor Emil Frankl (VEF) interviewed by James C. Overholser (JCO). [1]

Interview

JCO: We have a bit of time left. Let's get started. How does your approach to treatment align with other forms of psychotherapy?

VEF: "The new psychotherapy must be set up in contrast to all psychologistic theories which ignore the spiritual" (Frankl, 1961a, p.2). "We must look beyond psychogenesis … in order to see the distress of the human spirit" (Frankl, 1956, p.57). "Logotherapy calls upon the spiritual in man, and especially upon his will to meaning" (Frankl, 1958b, p.86). "Logotherapy is no substitute for psychotherapy, but its complement" (Frankl, 1955b, p.20).

JCO: So logotherapy confronts broad existential issues in session?

[1] Frankl often used the word "he" when we might now prefer the non-sexist phrase "they", or "man" when we might prefer "human".

VEF: "The aim of the psychotherapist should be to bring out the ultimate possibilities of the patient. Not to penetrate his deepest secrets but to realize his latent values" (Frankl, 1956, p.56). "True human wholeness must include the spiritual as an essential element" (Frankl, 1961a, p.2).

JCO: So it can be helpful to bring a spiritual view, but the therapist should stay out of religion and religious dogma?

VEF: "Of course" (Frankl, 1961b, p.5). "It seems to me that the various religious denominations are something like different languages. It is not possible … to declare that any one of them is superior to the others." (Frankl, 1967a, p.13). "Similarly, no language can justifiably be called 'true' or 'false'" (Frankl, 1967, p.13).

JCO: Many people today feel there is too much stress in society? Do you feel clients would benefit from interventions that include meditation and mindfulness strategies?

VEF: "This is not true" (Frankl, 1966/2016, p.8). "What man actually needs is not a tension-less state but rather the striving and struggling for some goal worthy of him" (Frankl, 1962a, p.113). "There is not only a pathology of stress, but also a pathology of the absence of tension (Frankl, 1962b, p.101).

JCO: So tension is good? But anxiety is wide spread - What are your thoughts on helping clients manage their feelings of anxiety?

VEF: "Man's search for meaning may arouse inner tension rather than equilibrium" (Frankl, 1984, p.109). "Out of a fear of anxiety, the patients … run from the anxiety (Frankl, 2004, p.110). "Fear tends to make come true precisely that which one is afraid of" (Frankl, 1967c, p.146). "Fear of fear is frequently caused by the patient's apprehensions about the potential effects of his anxiety attacks … the patient begins to avoid whatever situation used to arouse his anxiety" (Frankl, 1975a, p.226).

JCO: If you do not rely on medication or meditation, then how does a therapist help clients to manage their fear?

VEF: "Most of our patients react to their 'fear of fear' by 'flight from fear'; the patient begins to avoid situations that arouse his anxiety" (Frankl, 1975b, p.306). "The first thing to do is to take the wind out of the sails of the anticipatory anxieties" (Frankl, 1980, p.5). "Anticipatory anxiety is likely to trigger off what the patient so fearfully expects to happen" (Frankl, 1975b, p.306).

JCO: I have read some of your thoughts about paradoxical approaches. How does paradoxical intention work?

VEF: "Paradoxical intention consists in a reversal of the patient's attitude toward his symptom, and enables him to detach himself from his neuroses" (Frankl, 1960b, p.534). "To put it in a nutshell, paradoxical intention means that the patient is encouraged to do, or wish to happen, the very things he fears" (Frankl, 1967c, p.145). "In other words, the pathogenic fear is replaced by a paradoxical wish" (Frankl, 1966a, p.255).

JCO: So the key is a change of attitude change.

VEF: "Of course" (Frankl, 1974, p.10). "Even the negative aspects of human existence such as suffering, guilt and death can still be turned into something positive, provided that they are faced with the right attitude" (Frankl, 1965, p.57). "Through the right attitude, unavoidable suffering is transmuted into a heroic and victorious achievement" (Frankl, 1962b, p.101).

JCO: I have often wondered if paradoxical intention was an essential forerunner to contemporary approaches that rely on exposure therapy?

VEF: "Exactly!" (Frankl in Scully, 1995, p.4). "Similarities to the paradoxical intention technique can be discovered in the techniques called "exposure in vivo", … and prolonged exposure" (Frankl, 1975a, p.232).

JCO: So whether we talk about paradoxical intention or exposure therapy, how does it work?

VEF: "The obsessive-compulsive patient is characterized by his 'fight against obsessions and compulsions'. But alas, the more he fights them the stronger they become" (Frankl, 1975a, p.227). "If we succeed in bringing the patient to the point where he ceases to flee from or fight his symptoms … then we may observe that the symptom diminishes" (Frankl, 1960b, p.523).

JCO: And the symptoms are resolved because the attitude changed?

VEF: "Paradoxical intention is concerned not so much with the symptom in itself but, rather, the patient's attitude toward his neurosis and its symptomatic manifestations. It is the very act of changing this attitude that is involved whenever improvement is obtained" (Frankl, 1960b, p.527). "The purpose is to enable the patient to develop a sense of detachment toward his neurosis by laughing at it" (Frankl, 1960b, p.523). "In fact, paradoxical intention should always be formulated in as humorous a manner as possible" (Frankl, 1967c, p.149).

JCO: Let me change topics. Today, there is an emphasis on structured treatments and published manuals to guide psychotherapy sessions. What are your thoughts about these issues?

VEF: "It's all rot" (Frankl, 1955a, p.76). "Psychotherapy is always more than mere technique" (Frankl, 1981, p.75). "What counts in therapy is not techniques but rather the human relation between doctor and patient (Frankl, 1967b, p.139).

JCO: But what about novice therapists who are trying to develop skill in

psychotherapy techniques and strategy?

VEF: "I would go even further in my criticism" (Frankl, 1988, p.33). "A purely technological approach to psychotherapy may block its therapeutic effect" (Frankl, 1967b, p.139). "The doctor … who overestimates and idolizes method and technique, and who understands his role merely as that of a medical technician, only proves that he sees man as a mechanism, a machine" (Frankl, 1959, p.164).

JCO: But treatment manuals help to ensure fidelity across therapists so the same treatment is applied in a consistent manner across therapists and across different clients.

VEF: "How could this be possible?" (Frankl, 1965, p.54). "Each and every method of psychotherapy is not applicable to each patient with the same degree of success" (Frankl, 1967c, p.150). "Psychotherapy … depends on the constant willingness to improvise" (Frankl, 2004, p.29). "My interest lies neither in creating robots nor in raising parrots that just rehash their master's voice" (Frankl, 1981, p.71).

JCO: But modern standards are pushing for standardized treatments that can be examined in research programs. The field wants structured treatments that can be replicated across clients.

VEF: "But how can you say this!" (Frankl in Scully, 1995, p.41). "You have to modify the method not only from person to person but also from situation to situation; thus, you have not only to individualize but also to improvise" (Frankl, 1981, p.75). "If you treat two cases … in the same way, you have mistreated at least one of them" (Frankl, 1981, pp.74-75).

JCO: What are your thoughts about using guided discovery and collaborative empiricism as central to the process of psychotherapy sessions?

VEF: "I cannot say" (Frankl, 1966b, p.25). "Would you formulate some of your ideas for me?" (Frankl, 1969, p.38).

JCO: I have found value in the Platonic dialogues to help guide psychotherapy sessions. I try to use a series of questions to help clients establish their own goals and find their own solutions.

VEF: "I see" (Frankl, 1969, p.38). "Wonderful!" (Frankl, 1969, p.38).

JCO: So a Socratic style is compatible with your approach to therapy?

VEF: "Yes" (Frankl, 1969, p.38). "The physician nowadays must have the courage for such Socratic dialogues, if he takes his task seriously in treating man, not only illnesses" (Frankl, 1961c, p.63).

JCO: So a therapist uses questions to steer the client to find their own meaning?

VEF: "This is true" (Frankl, 1960a, p.9) "An appropriate method for such an inquiry may well be some sort of a Socratic dialogue" (Frankl, 1997a, p.87). "Meaning is something to discover rather than to invent" (Frankl, 1997a, p.113). "In psychotherapy it can be evoked by the posing of provocative questions in the frame of a maieutic dialogue in the Socratic sense" (Frankl, 1961b, p.6). "It is not necessary, however, to enter into sophisticated debates with the patients" (Frankl, 1962c, p.28).

JCO: Can you give me an example of how you would use a Socratic dialogue to help a severely depressed client to make a substantial shift in his views?

VEF: "An old general practitioner who consulted me because of his depression after his wife had died two years before" (Frankl, 1990, p.8). "How could I help him?" (Frankl, 1963b, p.31).

JCO: Yes, I am curious, how did you help him?

VEF: "Using a Socratic dialogue, I restricted my comment to asking him what would have happened if not his wife, but he himself would have died first. 'How terrible this would have been for her – how much she would have suffered" was his answer. Whereupon I reacted by asking him another question. 'Well, doctor, this suffering has been spared her. But now, you have to pay for it – by surviving and mourning her'. At the same moment, he began to see his own suffering in a new light, he could see a meaning in his suffering, the meaning of a sacrifice he owed to his wife" (Frankl, 1990, p.8).

JCO: So as a therapist, how would you work to shift a client's perspective?

VEF: "It is never up to the therapist to convey to the patient a picture of the world as the therapist sees it" (Frankl, 1962c, p.27). "It does not matter what I personally believe" (Frankl, 2010, p.152). "Logotherapists neither preach meaning nor teach it but learn it from people who for themselves have discovered and fulfilled it" (Frankl, 2004b, p.95).

JCO: So what might a therapist say to clients to help them discover meaning in their life?

VEF: "What should I say?" (Frankl, 1958a, p.32). "What would you say to yourself?" (Frankl, 1963b, p.33). "You are not 30 but instead 80 and lying on your deathbed. And now you are looking back on your life … What will you think of it?" (Frankl, 1984, p.139). "What do you think of when you look back up your life? Has life been worth living?" (Frankl, 1971, p.309).

JCO: This has all been very helpful but I see it is almost five o'clock.

VEF: "This will all have to end now, won't it?" (Frankl, 1963a, p.13).

JCO: Yes, but before we finish, let me ask - how have you accomplished so much throughout your career?

VEF: "I try to do everything as soon as

possible, and not at the last moment (Frankl, 2000, p.34). "I also am a perfectionist" (Frankl, 2000, p.22). As a perfectionist, I tend to ask a great deal of myself" (Frankl, 2000, p.33). "I have made it a principle to give the smallest things the same attention as the biggest, and to do the biggest as calmly as the smallest" (Frankl, 2000, p.34).

JCO: But isn't perfectionism likely to become a problem?

VEF: "We have to try to reach the absolutely best – otherwise we shall not even reach the relatively good" (Frankl, 1967a, p.17).

JCO: Before we run out of time, was there anything else you'd like to say?

VEF: "May I mention also some less serious interests? (Frankl, 2000, p.44).

JCO: Of course.

VEF: "Until my 80th year, mountain climbing was my favorite hobby" (Frankl, 2000, p.41). "Every important decision I have made, almost without exception, I have made in the mountains (Frankl, 2000, p.42). "Some of my friends suspect that my passion for mountain climbing is related to my interest in "height psychology" as I have called logotherapy … that is in contrast to the depth psychologies, which delve into the dark mysteries of unconscious dynamics" (Frankl, 2000, p.42-43). "Freud limited his research to the foundations, the deeper layers, the lower dimensions of human existence" (Frankl, 1967b, p.141).

JCO: Thank you for your words of wisdom. I believe your words have had a powerful influence on the field and you have made some timeless contributions to psychotherapy as well as my own personal perspectives on life and death matters.

VEF: "Thank you" (Frankl, 1969, p.38).

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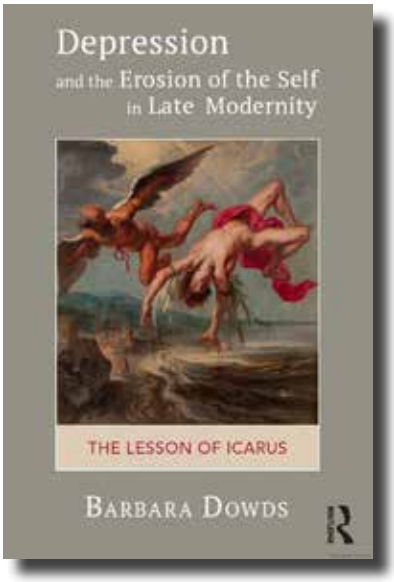
Book Review

Title: *Depression and the Erosion of the Self in Late Modernity: The Lesson of Icarus*
Author: *Dr. Barbara Dowds*
Published: *2018, Routledge*
ISBN: *ISBN:-978-1-78220-590-6*
Reviewed by: *Alan Kavanagh*

> "It is unethical to condemn so many to drug dependence and the belief that they are defective, that the problem is theirs individually, rather than ours collectively" (Dowds, 2018 p.xiii).

The above quote had an immediate effect on me. Initially, I was conflicted, as medication is sometimes warranted. Conversely, I was curious to learn why the author perceived psychotropic treatment as drug dependence. Through her research into implicit and explicit memory, she was intuitively motivated to write a book on this prevalent issue, which impacts us all, whether directly or indirectly. Dr. Barbara Dowds utilises her artistic licence in sharing her passionate perception and her vast eclectic knowledge, built upon the solid foundation of the pioneers in our field. Furthermore, this book challenges us to re-evaluate our perspective on this issue. Correspondingly, in an era of consumerism, a capitalist-driven culture of 'must haves' she suggests we are "starving in the midst of plenty" (2018, p.xiv). Conscientiously, I read this book, in the hope of finding answers to my own susceptibility to bouts of low moods and, amongst other things, it gave me an understanding "that low mood has always had an adaptive role to play" throughout our existence.



Like the author, I struggle with aspects of 'our current society'; however, while I might sound pessimistic, Barbara leaves no stone unturned on a macro or micro level to present the societal factors that are "detrimental to fulfilment of needs for relationship, rootedness, identity, understanding, and devotion in ways that generate vulnerability to depression and anxiety" (2018, p.256). The book's sub-sections entitled 'The Self: Experience and Development', 'The Science of Depression,' 'A Depressive Society? and The impact on the Self, Relationships, and Meaning' endeavour to explore the enervation that exists.

This book also pinpoints key attributes that may cause depression; however, it does not differentiate between the variations of depression. Additionally, it interweaves an analysis from twenty-one memoirs of depressive breakdowns, or what I prefer to describe as break-throughs. The book poignantly reflects that our focus is too much on the physiological and/or neuroscientific mechanisms, while overlooking the fact that our fundamental needs are growing increasingly difficult to satisfy in 'late modernity'. The author acknowledges, "we cannot rule out the possibility that the epidemic of depression is partly caused by trauma experienced by our ancestors" through epigenetics (2018, p.127).

> "Our genetic makeup changes slowly over thousands of years, so the current increase in depression cannot be ascribed to faculty genes." (2018, p.xiv).

Respectfully, the author understands the importance of not telling a single story of depression because focusing on one vantage point can be narrowing. As such, the book integrates a host of psychotherapeutic theories and the biopsychosocial model, and offers the reader a wide scope of understanding of the possible etiologies of depression. Personally, a pertinent part of the book related to learning about the NeuroAffective Relational Model (NARM), which proposes, "that the capacity for connection defines emotional health" (2018, p.73). The five needs: Connection, Attunement, Trust, Autonomy and Love-Sexuality are central to this integrative model.

A universal tiredness is present in society and perhaps, too casually; depression is deemed an illness as opposed to a humane response to life's trials and tribulations. This is not to minimise the symptoms of depression or its debilitating effects, however, Barbara's book, disputes the labelling of depression as solely innate. Conversely, it posits depression is "primarily a disorder of the self and only secondarily a mood disorder" (2018, p.193). Overall, this book is a brilliant contribution to our profession and, indeed, emphasises the trepidations in our society.