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What happened to individuality?

iacp
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Our Title

In Autumn 2017, our title changed from "Éisteach" to "The Irish Journal Of Counselling and Psychotherapy" or "IJCP" for short.

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Scripts:

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From the Editor:

Dear Colleagues

As counsellors and psychotherapists we know that there is no such thing as the average person. But how widespread is this belief?

Just before starting work on the summer edition of the IJCP I read a book titled The End of Average by Todd Rose. His thesis is that "any system designed around the average person is doomed to fail". I finished the book with a strong feeling of optimism and I have been preoccupied with its thesis i.e that the practice of standardizing and systematizing humankind around the average hasn't worked. Let me be clear Rose is not stating that averaging does not have a role to play in research design, but not in a "within group design".

At the outset he gives us the history of the onset of the Age of Average as he calls it, and how it came to be so valued in our culture. It started almost 200 years ago with the work of the Belgian mathematician and astronomer Adolphe Quetelet. By the 1840's almost every human variable; moral, physical and mental was standardised about the average (mean). Then later in the 19th century Sir Francis Galton a trained mathematician and member of the merchant classes in Britain had a more sinister part to play in this obsession with the average. I will give you a practical example of the difference between the two mens' conception of the average person.

If I were to carry out research on your ability as a counsellor and after working out my sums I informed you that you were an average counsellor how might you feel? Today people described as average on any human attribute might feel they were inferior or lacking. Well if I were relying on Quetelet's methodology of averaging, you would be considered the ideal, the perfect specimen of a counsellor, the norm. If your score deviated from the average you would be deemed to be an Error. If you deviated well outside the limits of average you would be deemed to be a "Monstrosity". It wouldn't matter if you scored above or below the average you would still be an Error.

On the other hand if I deemed you to be average based on Galton's method of transposing Quetelet's 'error' to 'rank, you would have every reason to be indignant. For Galton to be average was to be 'medicore, crude and undistinguished'. Galton ranked mankind into fourteen distinct classes from 'Imbeciles" in the lowest rank through "Medicore" to "Eminent" at the highest rank. He also developed the statistical construct of correlation with the idea of showing that if you were Eminent on one attribute you were also Eminent on other measures and vice versa. If you didn't know before how the words mediocre

and mediocrity became words of disparagement now you do.

After Quetelet and Galton in particular every possible human attribute and characteristic became standardized around the average or mean. Physicians and Poets alike opposed what was happening to the individual and individuality but their protests fell on deaf ears. Policy makers couldn't get enough of it. From the school curriculum to medicine and hospitals, to the workplace even to aircraft cockpits (at a huge cost to the American air force in the 1940's) individuals were all standardised around the mean. The individual became anonymous and irrelevant. The system became God.

This ideology became embedded in our institutions and the initiative and uniqueness of the person had no merit. Anyone who has ever tried to reason with a bureaucracy or large institution is well aware of this. Under attack the system closes in on itself. The recent scandal surrounding the cervical smear testing program in this country is a perfect case in point. Most of us know by now how Vicky Phelan was brought to the steps of the law Courts having been seriously injured by those responsible for her well-being is a perfect example of the machinations of a cold-hearted emotionally dysfunctional system closing in on itself to protect itself.

With the theme of standardisation in mind I turn to the articles selected for publication in this issue. You will recall Eugene McHugh opened up a conversation on the DSM in the spring edition. Dr. Terry Lynch has joined in with an overview of the validity of the manual. He reminds us that the goal of the DSM was to standardise the diagnoses of psychopathology that would facilitate research. He cites many well-informed commentators both within and without the DSM taskforce over the years since its genesis, who support his assertion that it is nothing but the collection of opinions of its authors – mostly psychiatrists. A very disquieting read. It should bring home to us the importance of being explicit advocates for our clients. If a client presents directly or indirectly through supervision with a mental illness diagnosis we should not hesitate to ask "who, why, what, where and when"?

We have two articles relevant to addictive behavior. Graham Gill-Emerson posits that trauma may well be the motivating force at the root of addiction. That addictive behavior is an attempt at a self-cure and there is a complexity of biopsychosocial factors at play in mediating and maintaining the behaviour.

Antoinnete Copely reviews the research on the effectiveness of Motivational Interviewing (MI) as a precursor to treatment for addiction. As always there are variables in the interviewing process that are difficult to standardise or control for. One such variable is the attunement between interviewer and interviewee.

We are also publishing part two of the simulated interview between Victor Frankel and James C. Overholser. For this writer anything said or written by Frankel is a pleasure to contemplate. His compassion is palpable. His assertion that despair is not pathological is a comfort. We can find a reason for living in the very experience of living itself. Read and enjoy!

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Practitioner Perspective

The Validity of the DSM: An overview

By Dr. Terry Lynch.

Strict adherence to the DSM-5 would remarkably result in fifty per cent of people supposedly having a so-called "mental disorder" by age 40 (Rosenberg, 2013). A conversation about the DSM is therefore welcome (McHugh, 2018).

The American Psychiatric Association describes the DSM as "the authoritative guide to the diagnosis of mental disorders", "the handbook used by health care professionals in the United States and much of the world" (American Psychiatric Association, 1). Given the authority generally bestowed upon the DSM, one might expect a commensurate level of validity as a core DSM characteristic.

The validity of the DSM-5

Arguably the world's most influential mental health organisation, the American National Institute of Mental Health's (NIMH) 2002-2015 director psychiatrist Thomas Insel wrote prior to DSM-5's publication:

> "While DSM has been described as a 'bible' for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been 'reliability' – each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity." (Insel, 2013)

At a 2005 American Psychiatric Association meeting, Insel stated that the DSM had "0% validity" (Johnston).

According to psychiatrist Steven Hyman, Insel's predecessor as director of the National Institute of Mental Health, the creators of the DSM:

> "Chose a model in which all psychiatric illnesses were represented as categories discontinuous with 'normal.' But this is totally wrong in a way they couldn't have imagined. What they produced was an absolute scientific nightmare." (Belluck, 2013).

DSM-IV Task Force lead psychiatrist Allen Frances has spoken of "DSM-5's flawed process and reckless product"; "discredited and scientifically unsound; "the gross incompetence of DSM-5" (Frances, 2013); "deeply flawed"; "untested". (Frances, 2012). Frances also wrote:

> "More than 50 mental health professional associations petitioned for an outside review of DSM-5 to provide an independent judgment of its supporting evidence and to evaluate the balance between its risks and benefits. Professional journals, the press, and the public also weighed in — expressing widespread astonishment about decisions that sometimes seemed not only

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to lack scientific support but also to defy common sense." (Frances, 2012).

No such independent review has been undertaken.

The validity of earlier DSM editions

The 1980 DSM-III is the most significant edition, heralding a major shift from psychoanalytic/psychotherapeutic perspectives to a biologically-focused approach. Prominent American psychiatrist Nancy Andreason wrote:

> "Although the authors of DSM-III knew that they were creating a small revolution in American psychiatry, they had no idea that it would become a large one and that it would ultimately change the nature and practice of the field." (Andreasen, 2007).

Andreasen continued:

> "DSM-III and its successors became universally and uncritically accepted as the ultimate authority on psychopathology and diagnosis. Validity has been sacrificed to achieve reliability. DSM diagnoses have given researchers a common nomenclature—but probably the wrong one. Although creating standardized diagnoses that would facilitate research was a major goal, DSM diagnoses are not useful for research because of their lack of validity." (Andreasen, 2007).

According to renowned British-based psychologist and author Dorothy Rowe:

> "Apart from where it deals with demonstrable brain injury, the DSM is not a valid document. The DSM is a collection of opinions. When the committee of psychiatrists change their opinions, a mental disorder might be removed from the DSM and some new one included. Believing in the DSM is much the same as believing in, say, the doctrines of the Presbyterian Church. Neither can point to evidence that supports the doctrine that lies outside the doctrine itself. When our ideas are supported by evidence, we can regard them as truths. Ideas unsupported by evidence are fantasies." (Rowe, 2010, p.130).

American physician and author Maria Angell MD, former Editor-in-chief of the New England Journal of Medicine, Senior Lecturer, Department of Global Health & Social Medicine, Harvard Medical School said:

> "Given its importance, you might think that the DSM represents the authoritative distillation of a large body of scientific evidence. It is instead the product of a complex of academic politics, personal ambition, ideology and, perhaps most important, the influence of the pharmaceutical industry. What the DSM lacks is evidence.
>
> The problem with the DSM is that in all of its editions it has simply reflected the opinions of its writers. Not only did the DSM become the bible of psychiatry, but like the real Bible, it depends on something akin to revelation. There are no citations of scientific studies to support its decisions. That is an astonishing omission, because in all medical publications, whether journals or books, statements of fact are supposed to be supported by citations of scientific studies". (Angell, 2009).

Proponents of a biologically-slanted perspective argue that failure to identify cause is common to both many medical illnesses and many "mental illnesses".

American psychologist, social justice and human rights activist Dr. Paula Caplan is a former professor of psychology, assistant professor in psychiatry and director of the Centre for Women's Studies at the University of Toronto. Her illustrious career included a Presidential Citation and a Distinguished Career Award from the Association for Women in Psychology. Caplan was an invited consultant to two committees involved in the creation of the DSM-IV. In 2014 she wrote:

"I resigned from those committees after two years because I was appalled by the way I saw that good scientific research was often being ignored, distorted, or lied about and the way that junk science was being used as though it were of high quality, if that suited the aims of those in charge. I also resigned because I was increasingly learning that giving someone a psychiatric label was extremely unlikely to reduce their suffering but carried serious risks of harm, and when I had reported these concerns and examples of harm to those at the top, they had ignored or even publicly misrepresented the facts." (Caplan, 2014)

In 1995 Caplan wrote:

> "As a former consultant to those who construct the world's most influential manual of alleged mental illness, I have had an insider's look at the process by which decisions about abnormality are made. As a longtime specialist in teaching and writing about research methods, I have been able to assess and monitor the truly astonishing extent to which scientific methods and evidence are disregarded as the handbook

is being developed and revised. I could not attempt in a single book to address the vast array of its biases, examples of its sloppiness and illogical thinking, and just plain silliness. Mental disorders are established without scientific basis or procedure." (Caplan, 1995, xv, 90).

Paula Caplan cites psychologist Lynne Rosewater, who participated in a DSM-III committee:

"They were having a discussion for a criterion about Masochistic Personality Disorder and Bob Spitzer's wife says 'I do that sometimes', and he says, 'Okay, we'll take it out'". (Caplan, 1995, p. 91).

Robert (Bob) Spitzer was the lead psychiatrist of the DMS-III Task Force. Psychologist Renee Garfinkle also attended DSM-III committee meetings. She subsequently said:

"The low level of intellectual effort was shocking. Diagnoses were developed on the majority vote on the level we would use to choose a restaurant. You feel like Italian. I feel like Chinese. So let's go to a cafeteria. Then it's typed on a computer". (LeGault, 2006, p. 91).

"Mental disorder"

The centrality of "mental disorder" to the DSM is illustrated in its name – The Diagnostic and Statistical Manual of Mental Disorders. One might assume that this term's meaning would be without ambiguity.

Aforementioned psychiatrist Allen Frances – lead psychiatrist of the DSM-IV Task Force – said in a 2010 interview: "There is no definition of a mental disorder. It's bullshit. I mean, you just can't define it." (Greenberg, 2012). In a Twitter conversation with me, Frances wrote: "I've read 50 definitions of mental disorder/ wrote one. None helpful." (Frances, 2017). DSM-5 Task Force vice-chair American psychiatrist Darrel Regier wrote: "Mental disorder definitions . . . are almost impossible to test." (Regier, 2012).

One person had been attending psychiatrists continuously for six years with a diagnosis of "clinical depression". She was repeatedly told that she had a biological illness, a brain chemical imbalance – which incidentally has never been verified to exist in any human being – and that her psychiatrists would eventually find the right drug combination.

DSM Depression criteria

Problems arise even within DSM sections generally considered uncontroversial. In my best-selling book Beyond Prozac I wrote:

"Why did the American Psychiatric Association select five criteria as the magic figure? What is so different between a person who meets six criteria — and is therefore diagnosed as having a Major Depressive Episode and needing antidepressant treatment — and one who meets four criteria, and therefore receives no psychiatric diagnosis or treatment? Why five criteria? Why not three? Or seven? How valid are these criteria?" (Lynch, 2001, p.81).

Nine years later, American psychiatrist Daniel Carlat put similar questions to Robert Spitzer, lead psychiatrist of the 1980 DSM III Task Force, the psychiatrist responsible for introducing these criteria:

Carlat: "How did you decide on 5 criteria as being your minimum threshold for depression?"

Spitzer: "It was just consensus. We would ask clinicians and researchers, 'How many symptoms do you think patients ought to have before you give them a diagnosis of depression?' And we came up with the arbitrary figure of five."

Carlat: "But why did you choose five and not four? Or why didn't you choose six?"

Spitzer: "Because four just seemed like not enough. And six seemed like too much."

Robert Spitzer "smiled impishly" as he uttered the last sentence. (Carlat, 2010, p. 53).

British psychologist James Davies also interviewed DSM-III lead psychiatrist Robert Spitzer. Spitzer having admitted that no biological abnormalities had been identified in any psychiatric disorder, Davies asked, "So without data to guide you, how was this consensus reached?" Spitzer replied:

"We thrashed it out basically. We had a three-hour argument. There would be about twelve people sitting down at the table...and at the next meeting some would agree with the inclusion, others would continue arguing...if people were still divided. the matter would be eventually decided by a vote." (Davies, 2013, pps 22, 29, 30).

"Biology never read that book"

A peculiar situation pertains in relation to psychiatry and the DSM. Mainstream psychiatry has long asserted that the experiences and behaviours understood as "mental illnesses" are fundamentally biological. The virtual absence of any evidence verifying these claims paints a different picture – as does the absence of characteristic physical examination findings and diagnostic laboratory/radiological tests, which

A common assertion regarding so-called "mental disorders" is that they are medical conditions. This claim has been made so widely and for so long that it is generally assumed to be an established fact.

are never carried out to diagnose "mental illness", only to exclude known organic disease, check drug levels and check bodily functions, given the potential for drug toxicity.

Proponents of a biologically-slanted perspective argue that failure to identify cause is common to both many medical illnesses and many "mental illnesses". However, the correct categorisation of biological illness depends not on causation but the presence of verified biological abnormalities – pathology. The cause of many cancers is not known, but so established is the pathology of cancer that one will rarely hear questioning of the centrality of biological pathology – e.g. cancer cells – to cancer.

A corresponding fundamental weakness – the lack of scientific verification of biological pathology – surfaces throughout the DSM-5. The virtual absence of reference to biology within the DSM-5 has been highlighted by the aforementioned Thomas Insel MD:

> "As long as the research community takes the DSM to be a bible, we'll never make progress. People think that everything has to match DSM criteria, but you know what? Biology never read that book." (Belluck, 2013).

By 2013, the National Institute of Mental Health had all but abandoned the DSM-5, "re-orienting its research away from DSM categories". (Insel, 2013). The lack of biological verification has been acknowledged by the Chair of the DSM-5 Task Force, American psychiatrist David J. Kupfer MD:

> "The problem that we've had in dealing with the data that we've had over the five to 10 years since we began the revision process of DSM-5 is a failure of our neuroscience and biology to give us the level of diagnostic criteria, a level of sensitivity and specificity that we would be able to introduce into the diagnostic manual". (Belluck, 2013).

De-emphasising psychological-mindedness

The DSM is akin to a distorted radar system, set up to pick up certain aspects of human experience and behaviour and miss others, and to interpret these experiences and behaviours in ways that exclude other often more legitimate ways of understanding these experiences and behaviours. In his 2010 book, psychiatrist Daniel Carlat wrote of the DSM:

> "It has drained the color out of the way we understand and treat our patients. It has de-emphasized psychological-mindedness, and replaced it with the illusion that we understand our patients when all we are doing is assigning them labels." (Carlat, 2010, p. 60).

In my work in mental health, I regularly encounter people given various DSM diagnoses, core aspects of whose stories have been largely or completely missed. On the day of writing this, two such clients attended me. In both cases the diagnosis happened to be "clinical depression", but I regularly encounter this phenomenon across the range of psychiatric diagnoses.

One person had been attending psychiatrists continuously for six years with a diagnosis of "clinical depression". She was repeatedly told that she had a biological illness, a brain chemical imbalance – which incidentally has never been verified to exist in any human being – and that her psychiatrists would eventually find the right drug combination. At our first meeting, a significant narrative emerged involving major parental attachment problems and loss of selfhood since early childhood. This narrative, known to be associated with depression, previously went unnoticed, unexplored, unresolved.

The second client had attended her GP on three separate occasions, and was told each time that she had "clinical depression" and that medication was the answer. Within these exchanges, a raft of emotional and psychological issues went unnoticed and unaddressed, including considerable trauma, rejection and abandonment issues, selfhood reduction, much unfinished business, learned helplessness and powerlessness, all of which fed into the experiences and behaviours labelled as "clinical depression".

The People Behind DSM-5

According to the American Psychiatric Association, which produces and publishes the DSM:

> "The DSM-5 development process has involved not only psychiatrists, but also experts with backgrounds in psychology, social work, psychiatric nurs¬ing, pediatrics, and neurology. DSM-5's Task Force and 13 Work Groups include more than 160 mental health and medical profession¬als who are leaders in their respective fields. The selection of such a diverse group of professionals means that a multitude of viewpoints is being considered in each decision". (American Psychiatric Association, 2)

However, nearly 100 of the 160-plus Task Force and Work Group members were psychiatrists. Less than half this figure – 47 – were psychologists; just one social worker, and no psychotherapist/counsellor.

The control centre within the DSM-5 was the American Psychiatric Association-appointed Task Force, consisting of 35 members. Both chair and vice-chair were psychiatrists. The remaining 33 members included 25 psychiatrists, 3 psychologists and not a single psychotherapist, counsellor, social worker, or occupational therapist. The emergence of a medicalised approach with the DSM is therefore hardly surprising.

"Mental disorders" as medical conditions

A common assertion regarding so-called "mental disorders" is that they are medical conditions. This claim has been made so widely and for so long that it is generally assumed to be an established fact. Eugene McHugh quotes a 2014 book which refers to "the philosophical assumption that mental disorders are medical conditions". (Dailley, 2014 p. 15). This book's authors referred to two major underpinning philosophical changes within the DSM:

> "The first philosophical change involves a shift in focus from phenomenological interpretations (i.e., symptom identification and behavioral observations–a medical model) to identifiable pathophysiological origins (i.e. functional changes associated with or resulting from a disease or injury–a biological model". (Dailley, 2014 p. 17).

I was struck by aspects of this passage. Published by the American Counseling Association, this book is written by experienced counsellors for counsellors. The medical model has long been primarily a biological model. I would caution against accepting without question the profoundly significant "philosophical assumption that mental disorders are medical conditions".

Rather than embrace the DSM, I encourage the counselling professions to press for trauma-informed responses, within which experiences and behaviours are accepted and addressed in their own right,

Many authoritative medical sources do – wrongly – claim that psychiatric diagnoses are known brain disorders. The highly influential US National Institute of Mental Health (mis)informs its readers that "mental illnesses are disorders of the brain", and "Through research, we know that mental disorders are brain disorders". (National Institute of Mental Health).

If psychiatric diagnoses were verified biological disorders, they would appear within authoritative comprehensive lists of brain and neurological disorders. All of the major comprehensive such lists I have reviewed include no psychiatric diagnosis as a known brain disorder, including a sister organisation of the National Institute of Mental Health. (National Institute of Neurological Disorders and Stroke).

Conclusion

The experiences and behaviours diagnosed as various "mental disorders" are real and valid. The interpretation of these as primarily biological entities within the DSM framework is not valid, fostering a dominant modus operandi that may have prompted global trauma expert psychiatrist Bessel van der Kolk to create a video entitled "Psychiatry must stop ignoring trauma". (van der Kolk, 2015).

Following publication of the DSM-5, the Division of Clinical Psychology of the British Psychological Society issued a Position Statement calling for "a paradigm shift" away from a "'disease' model". (British Psychological Society, 2013).

The words of Louise Armstrong, author of many books including Kiss Daddy Goodnight – a ground-breaking book on incest – are accurate:

> "To read about the evolution of the DSM is to know this: The DSM is an entirely political document. What it includes, and what it does not include, is the result of intensive campaigning, lengthy negotiating, infighting and power plays." (Le Gault, 2006, p. 91).

Rather than embrace the DSM, I encourage the counselling professions to press for trauma-informed responses, within which experiences and behaviours are accepted and addressed in their own right, rather than repackaged as "mental disorders" within a system whose "bible" is utterly lacking validity.

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Practitioner Perspective

A critical evaluation of Miller and Rollnick's Motivational Interviewing as an approach for working with substance misuse

By Antoinette Copley

By listening reflectively and eliciting change statements from the client it becomes possible to help the client reduce the level of perceived discrepancy between their actual behaviour and their ideal behaviour

Introduction

Theories examining the reasons why some individuals change harmful behaviours while others do not, provide us with important perspectives on the factors that promote behavioural change and maintenance. The purpose of this article is to critically evaluate how one such theory, Miller and Rollnick's theory of Motivational Interviewing (MI), promotes individual behavioural change in relation to substance misuse. In order to do this the article will critically evaluate available empirical evidence of how this theory is supported when it is applied in a variety of settings to determine its validity in the light of the evidence.

What is MI

Within the broad area of substance misuse, MI is a technique developed by Miller and Rollnick that views a client's motivation for change as malleable, unlike the traditional view which viewed motivation as a stable personality trait of the client (Miller & Rollnick, 2002; Schneider, 2000). The MI practitioner uses a client-centred style of engagement designed to help clients explore and resolve their ambivalence about changing. The practitioner focuses on the client's readiness for change using this technique by applying client-centred principles that include an accurate understanding of the client's view, building trust and increasing the client's self-efficacy. By listening reflectively and eliciting change statements from the client it becomes possible to help the client reduce the level of perceived discrepancy

Those who were assigned for enhanced evaluation were more likely to attend further treatment sessions throughout the 28-day-follow-up than those who received the standard substance intake evaluation

between their actual behaviour and their ideal behaviour and thus the practitioner evokes change rather than imposing it (Miller & Rollnick, 2002). Over the last decade or so the practice of MI has become increasingly popular as an approach within the field of substance misuse and therefore it is important to establish whether it is helpful, harmful or ineffective.

MI as an approach to treat substance misuse

The efficacy of MI has been demonstrated in several studies including systematic reviews indicating empirical support for its use in reducing substance use and increasing willingness to participate in drug treatment programs. In a recent randomised control trial (RCT) that compared the effects of two sessions of MI (intervention group) with treatment as usual (control group) on the reduction of substance use in a psychiatric population, the authors found a significant reduction in frequency of substance use among the intervention group when compared with the control group over the two years of the study (Bagoien et al, 2013). Another RCT of incarcerated adolescents found a higher level of engagement in substance use treatment among the adolescents who received MI compared with those who received relaxation therapy (Stein et al, 2006). MI has also been shown to be useful in a community setting and appears to work successfully when integrated with other strategies. In an RCT of 423 substance-users who entered outpatient treatment in five community-based settings and who were randomly assigned to receive integrated evaluation that included MI techniques or to a standard intake evaluation, those who were assigned for enhanced evaluation were more likely to attend further treatment sessions throughout the 28-day-follow-up than those who received the standard substance intake evaluation (Carroll et al, 2006). Miller himself carried out a review of three clinical trials evaluating MI as a prelude to entering treatment programs for substance misuse whereby participants were randomly assigned to a single session on MI prior to treatment (Miller & Rose, 2009). In all three studies participants who received the single session of MI showed increased rates of abstinence at follow-up and were more likely to attend further treatment sessions.

In a synthesis of data from twenty-one studies of young people it appears that MI interventions have resulted in small but statistically significant reductions in substance misuse (Jensen et al, 2011). Further effectiveness of MI was demonstrated in a systematic review of 29 RCTs that assessed MI in relation to four risky behaviours (Dunn, 2001). The author noted that there was strong evidence for MI as an effective intervention noting that it was particularly useful for enhancing willingness to engage with further treatment sessions particularly in relation to problem drinking. The author did not however find adequate evidence to be able to assess the effect of MI on the other risky behaviours. Similarly, a later systematic review noted that while MI generated significant results when compared with other treatments in relation to drinking cessation or reduction, the efficacy of using MI for other risky behaviours like smoking was not supported in the author's meta-analyses of the studies they included in their review (Burke, Arkowitz, & Menchola, 2003). Burke et al did however note that in the studies they examined, change in drinking behaviour occurred in considerably less time using MI as an intervention than with other interventions. Therefore, the apparent cost-effectiveness of MI may be a factor contributing to its rise in popularity.

For some practitioners and service planners the appeal of MI as an approach for treating substance misuse is not just its brevity compared with other approaches but also its cost-effectiveness

For some practitioners and service planners the appeal of MI as an approach for treating substance misuse is not just its brevity compared with other approaches but also its cost-effectiveness (Heather, 2005). According to Heather, there are obvious advantages to any treatment modality that can achieve behavioural change in fewer sessions when compared with other approaches. However, Heather cautions that such brief

interventions have higher rates of success in populations with low levels of substance misuse but they are not so successful where dependence levels are high. Nonetheless, such effective brief interventions delivered early and at low costs to populations where dependence levels are low, could be used as part of a public health approach to reducing levels of substance misuse and in turn reduce substance-related harm. However, cost-effective treatments are not enough if they are ineffective and the fact that there appears to be wide variation in effect sizes of the different outcomes measured, a closer inspection of MI is warranted.

Variability in outcomes and in the application of MI

A review that examined MI interventions on substance misuse in adolescents looked at the differences between the intervention formats used in the 39 different studies (Barnett, Sussman, Smith, Rohrbach, & Spruijt-Metz, 2012). The review found that overall 67% of the studies reported positive substance use outcomes. However, no significant differences were found between the different intervention formats used that included using feedback or not, or using combined treatment intervention formats compared with MI alone. The authors of another systematic review to assess the effectiveness of MI on drug use, retention in treatment and readiness to change, found mixed results between the 59 RCT studies carried out up-to November 2010 (Smedslund et al, 2011). In this review, the authors examined studies that compared other/no treatments to an MI intervention. No treatment compared with an MI intervention showed a significant effect post-intervention but the effect was weaker in the short and medium follow-up terms. Regarding the extent of substance misuse, MI did better than treatment as usual at the medium-term follow-up but there was no effect of MI at the short-term follow-up. The authors of this review noted that there was an overemphasis on the importance of the treatment modality with less focus given to the practitioner's or the client's role on substance use outcomes. The level of variability in study outcomes carried out in a variety of settings suggests an imperative to understand why some interventions work while others do not. One explanation for this may be linked to the process of delivery.

Allsop argues that while practitioners require comprehensive training and skills in order to embrace the spirit of MI, this varies widely by practitioner.

The practitioner's contribution to outcome variability

There appears to be a level of complexity in the delivery of MI that warrants judicious application by the practitioner (Allsop, 2007). Allsop argues that while practitioners require comprehensive training and skills in order to embrace the spirit of MI, this varies widely by practitioner. The client-practitioner relationship has been well established as a contributory factor to the efficacy of MI (Miller & Rose, 2009). Despite this, there is wide variation in practitioner levels of competence to use the skills necessary to apply MI appropriately (Lundahl, 2009). According to Lundahl the ability to ask open-ended question, to use reflective listening and to be able to summarise the client's statements are all essential skills for an effective MI practitioner. In addition to this, the practitioner also needs to adhere to the principles of person-centred therapy laid down by Carl Rogers that include accurate empathy, congruence and positive regard if they are to foster an environment that allows the client to explore the possibilities of change (Miller & Rose, 2009). Added to the above issues, a poorly trained practitioner may elicit client resistance by inadvertently setting up any one of a series of twelve potential "roadblocks" (e.g. giving advice, making suggestions or providing solutions) arising out of their own poor reflective listening skills (Miller & Rollnick, 2002). In addition to the contribution that practitioners make to the level of variability in study outcomes, the client may also have a role to play.

When it was compared with two other established treatments no effect was found in MI condition but significantly increased levels of readiness were found in the other two treatments

The client's contribution to outcome variability

Client behaviour may be another factor in predicting outcomes associated with MI but it seems the results vary depending on which mechanism of the client's behaviour is being examined and what it is being compared

Apodaca also noted that client readiness to change varied depending on the control conditions. Increased readiness to change was more evident when MI was compared with a minimal/placebo condition (e.g. relaxation training or education) but less evident when compared with standard care.

with (Apodaca, 2009). In a systematic review of nineteen RCTs that examined several different mechanisms of client behaviour, Apodaca noted that clients of an MI intervention were more likely to report higher levels of intention to change their substance use behaviour than clients who received standard care and that change talk was a likely mediator of that change. Apodaca also noted that client readiness to change varied depending on the control conditions. Increased readiness to change was more evident when MI was compared with a minimal/placebo condition (e.g. relaxation training or education) but less evident when compared with standard care. Additionally, when it was compared with two other established treatments no effect was found in MI condition but significantly increased levels of readiness were found in the other two treatments. However, Apodaca noted with surprise that those studies did not report the relationship between post-treatment readiness to change and substance use behaviour. In other studies examined for Apodaca's review, the client's level of engagement in the process was highest in MI condition when compared with both minimal/placebo and standard care conditions. In addition greater engagement significantly impacted on substance use behaviour. Client resistance to change was also examined in this review with Apodaca noting how few of the studies in his review examined this mechanism. The study that did review it reported that MI had a small but significant effect on reducing resistance when compared with confrontational therapy and that higher levels of resistance during an intervention resulted in worse outcomes. The variable effectiveness of MI as dependant on client behaviour mechanisms is also apparent among different population groups.

Cultural variation in the efficacy of MI was evident in one meta-analysis where the effect size of MI on recipients was doubled when participants were predominantly ethnic minorities compared with white, non-Hispanic Americans (Hettema, Steele, & Miller, 2005). Native Americans have also been shown to have a significantly more positive response to MI when compared with other treatment interventions such as cognitive-behavioural therapy or 12-step programmes (Villanueva, Tonigan, & Miller, 2007). Winhusen et al (2008) also found evidence in their RCT that MI had a significantly more beneficial effect on the drug use of pregnant users from ethnic minority backgrounds. Such findings are important as according to Miller & Rollnick (2002) cultural factors affect how individuals perceive their own behaviour and how they weigh up the effect that the behaviour is having on their lives. Service providers and practitioners should further investigate the role of both client behaviour and their socio-demographic characteristics that include cultural differences, in order to better understand the mechanisms of change underlying MI.

Conclusion

The aim of this article was to critically evaluate how Miller and Rollnick's theory of MI promotes individual behavioural change in relation to substance misuse. The article reviewed empirical evidence to determine how this theory was supported when it was applied in a variety of settings. This review found that MI had a variable effect on substance use outcomes. The studies examined for this review were RCTs or systematic reviews of RCTs that compared an MI intervention with other or no interventions. The results showed that MI compared favourably to no intervention or to standard interventions with positive effects on substance use behaviour noted. However when MI was compared with other established treatments, such as giving feedback or other forms of psychotherapy, the effect size was either small or there was no significant effect. Nevertheless, the review found no evidence that MI causes harm to clients and there was evidence that is was helpful in some circumstances whereby it assisted in engagement

New research is needed to establish the causal mechanisms of change underlying MI that should include socio-demographic characteristics as well as client behaviour.

with further treatments. The review highlighted some possible explanations for the different levels of variation that included the practitioner's skill level, the client's own behavioural mechanisms of change and cultural explanations. While there appears to be no shortage of studies examining when MI works there is a paucity of research into how or why it works. New research is needed to establish the causal mechanisms of change underlying MI that should include socio-demographic characteristics as well as client behaviour. In addition there is a further need to explore the optimal method of delivery of MI so that practitioners can become more proficient in this treatment method.

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Practitioner Perspective

Addiction and the Trauma Experience

By Graham Gill-Emerson

At a time in society when we are experiencing a paradigm shift in people talking publicly about their struggles with mental health (See Change, 2012), there remains a very clear stigma and separation associated with addiction (Citywide, 2016; Turning Point, 2016).

The discourse around addictive behaviour in the mental health community can be lively and at times divisive (Dual Diagnosis Ireland, 2018). It has the potential to exclude clients from much needed support with many mental health services at times withholding treatment until the addiction is addressed and vice versa. The National Advisory Committee on Drugs reported that both addiction (58%) and mental health (43%) services reported exclusion criteria applied to people with a dual diagnosis (MacGabhann et al., 2004).

There are many theories as to the origins and maintenance factors of addiction, many locating it at some point or another within the biopsychosocial paradigm. It is often identified as a behavioural issue, a moral issue, a social issue or a disease (Abel & O'Brien, 2014).

Given the separate perspectives of what addiction could be one wonders if there is a unifiying theoretical perspective that could offer a container to hold aspects of each theory. Such a critical piece of the addiction jigsaw would have to fit the various addiction treatment perspectives while offering a unifying element that could weave each together.

To that end, this article will offer an exercise in panning out, exploring addictive behaviour through a broader biopsychosocial lens framed as a coping strategy (mal-adaptive or otherwise) amplifying and/or stemming from the existence of a trauma history.

Trauma

Trauma is an experience that fundamentally alters how we interact with the inside and outside world by modifying our body and brains so that we become intrinsically reactive to triggers in our environment. In a nutshell, trauma is the result of a real or perceived life-threatening event, or series of on-going abuse or neglect, that is imprinted on the brain in such a manner that any reminder of the event (direct or indirect) send the person into a fight/flight/freeze/faint response.

Trauma impacts the quality of life affecting sufferer's mental health, relationships, work and self-concept. A traumatising event can move individuals from the experience of 'happening in the world' to individuals that experience 'the world as happening to them'.

Trauma can span from neglectful or abusive experiences in childhood up to singular grand events throughout the lifespan. When thinking of trauma it is helpful to identify it through two factors of the frequency and intensity of the event(s). Frequency looks at what history of traumatic events an individual has experienced and explores the types of trauma that may have occurred. Types of trauma can include single or multiple incidents, developmental trauma where one

grows up experiencing abuse or neglect and intergenerational trauma where one's grows up around traumatised caregivers. When considering trauma, one should reflect on the age of first onset. This can aid the therapist in identifying the level of internal resources developed before the event(s) took place and aiding the therapist in treatment planning (Rothschild, 2000).

Intensity refers to the extent of the psychological shock experienced. Big 'T' traumas are experiences that would be overwhelming to just about anyone and that often involve perceived life threatening and bodily integrity components, such as assault, road traffic collisions, or hostage situations. whereas Small 't' traumas are upsetting circumstances that life throws our way and if not integrated into our system of understanding have the potential to accumulate and cause as many issues as big 'T's (Shapiro, 2001).

The roots of how trauma develops are found in how the brain manages terrifying events. Our brains are hard wired with a set procedural response to frightening situations as a means of optimising the likelihood of the individual's survival (Levine, 1997). These procedural response (fight/flight/freeze/faint) are aligned with the physical structures of the brain.

The triune brain is a model (See Fig 1) of understanding the topographical structure of the brain through the evolution of the human species (McLean, 1990). It points to three distinct levels of operation in us all:

- The reptilian brain is the oldest part at the base of the brain and is responsible for fight/flight/freeze/faint responses
- The limbic or mammalian brain is responsible for emotion
- The neo-cortex or neo-mammalian brain is responsible for complex thinking (strategizing, language, etc.)

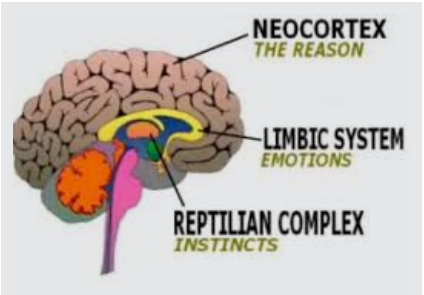

Fig 1: The Triune Brain Model

When as humans we perceive ourselves to be in immediate danger, our neo-cortex is shut down as function switches to the survival protocols of the reptilian brain. The reason for this is that when one's life is in immediate danger, time spent strategizing can be fatal and decisive action takes precedence.

The trouble arises when one experiences a situation as traumatic and is unable to integrate it. One of the residual effects of trauma is the reptilian and limbic brain remaining engaged and in a heightened state (hypervigilance) seeing and feeling everything as a possible danger and reacting to meet it. Bessel Van der Kolk (2014) likens this response to a faulty smoke alarm set off by the most innocuous of triggers.

Such toxic stress has been found to have profound negative implications across the lifespan. This dynamic has been looked at through the Adverse Childhood Experiences study, one of the biggest trauma studies ever to have been conducted (Shonkoff & Garner, 2012).

Adverse Childhood Experiences

The biopsychosocial strands of how trauma can affect negative life outcomes are best demonstrated through the Adverse Childhood Experience (ACE) Study conducted by Felitti et al. (1998) in conjunction with US Centre for Disease Control (CDC) and Kaiser Permente Hospital in California.

The study, carried out on some 17,000 individuals, explored the relationship between traumatic childhood events and later negative life outcomes. A series of questions across three domains of abuse, neglect and household dysfunction are tabulated to give a score from low adverse childhood experiences (ACE's) at 0 and a maximum ACE score at 10.

The researchers demonstrated a dose response of childhood trauma to the increased likelihood of many negative life events.

They showed that an ACE score of three marked the pathological threshold, meaning that any one of us could have up to three ACE's and remain relatively well. They found however that after this point, susceptibility to negative life experiences and thus propensity

Though this study was first conducted within a private hospital with middle and upper class individuals with health insurance, it has been replicated across many communities of various socio-economic backgrounds and has maintained an exceedingly high rate of correlation in its results.

The research seems unambiguous on the co-morbid nature of addiction and trauma with a number of authors suggesting a functional relationship between both disorders.

for further traumatisation get progressively worse.

With an ACE score of four they found that over half of such individuals report having a learning or behavioural problem, rates of depression were 5 times higher and this group were 12 times more likely to attempt suicide in their lifetime. People with this score were also 6 times more likely to have been raped and 7 times more likely to have an addiction to alcohol.

At an ACE score of six individuals were 46 times more likely to be involved in IV drug use and their likelihood of attempting suicide jumped to being 50 times more likely in the lifetime. At a biological level, the toxic stress encountered by having such a high ACE score resulting in the group (ACE of six) being twice as likely to have had cancer and four times as likely to suffer from emphysema.

Though this study was first conducted within a private hospital with middle and upper class individuals with health insurance, it has been replicated across many communities of various socio-economic backgrounds and has maintained an exceedingly high rate of correlation in its results. The Center for Disease control's Behavioral Risk Factor Surveillance System (BFRSS), an annual study across 32 US states noted that'regardless of the data source, study findings repeatedly reveal a graded dose-response relationship between ACEs and negative health and well-being outcomes across the life course.' (Centers for Disease Control & Prevention, 2016).

Felitti et al. (1998) hypothesised the mechanism below (See Fig 2) by which increased ACE's impact biopsychosocial development ultimately limiting an individual's ability to actualise and increasing the susceptibility to further trauma, disease, social issues and early death. It's results as they pertain to addiction offer greater insight in to its traumatic origins.

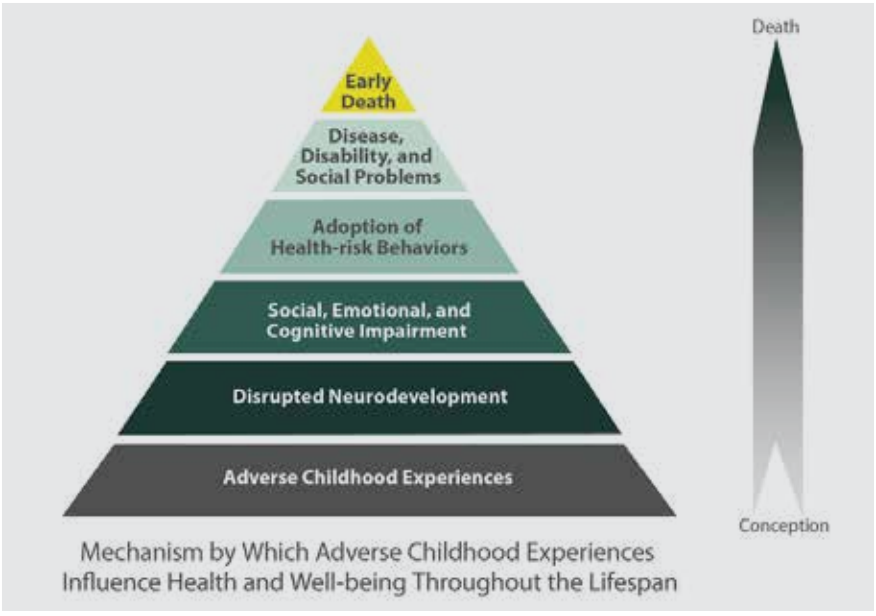

Fig 2: The ACE Pyramid (Felitti et al., 1998).

Trauma as a predictor of addiction

Those presenting with a dual diagnosis of addiction and trauma is more common than not in the addiction treatment field. Back et al. (2008) found that two thirds of people seeking treatment for substance use disorders report one or more traumatic life events while Jacobsen et al. (2001) found that up to 75% of clients presenting with addiction have comorbid histories of trauma.

Najavitz (2002) found that of the clients sampled in substance abuse treatment 12% – 34% have current post traumatic stress disorder; looking at women alone these rates increased to between 33% – 59%. With rates of trauma this high in those attending substance abuse treatment one can only imagine the levels for trauma in the broader substance abuse community, particularly those that do not manage to access treatment.

The research seems unambiguous on the co-morbid nature of addiction and trauma with a number of authors suggesting a functional relationship between both disorders, which is largely supported by empirical evidence (Van Dam et al., 2012). Such empirical evidence points to a crossover in the dysregulation of hormonal systems found in those that suffer from both conditions.

Systems of Dysregulation

As can be seen in the ACE pyramid, trauma (and especially

early life trauma) can disrupt neurodevelopment. Just as dysregulation occurs in the physical structures of the brain, similar dysregulation is present at a hormonal level.

The endorphin system regulates through social connection and is compromised by the social contraction or isolation that characterises both the experiences of trauma and addiction.

The Dopamine System

The dopamine system is the system at play when people become triggered by the people, places, things and emotions associated to their addictive behaviour. It is the chemical system responsible for motivation and when dysregulated (too much or too little) prevents the addicted person from rationally weighing up the short term positive effects of behaviour from the longer term negative consequences. Dopamine dysregulation is implicated in the fixated 'now, now, now' mentality and it is often reflected through the addicted person's pendulation between instant gratification and extended lethargy.

Additionally, there is evidence that trauma also disrupts this system having been implicated in post-traumatic depression (Ogden, Milton & Pain, 2006) and in trauma triggering when there is a re-diversion of energy through the central dopamine mechanism, away from the planning and thinking mode of the neocortex to the survival mode of the reptilian brain (DeBellis & Zisk, 2014). Such diversion of energy has implications in the individual suffering from addiction and/or trauma as it prevents the use of coping strategies they have learnt in treatment as the area of the brain (neo-cortex) needed to carry out such responses becomes unavailable. In essence, the lack of availability of the pre-frontal cortex highlights why teaching clients to master grounding techniques must come before any other sort of refusal or relapse prevention skill as it is integral to recovery management for either or both conditions.

The Endorphin System

All addicted people experience a dysregulation of the dopamine system (Hall, 2013) but some experience imbalance within a further system.

Endorphin dysregulation is not as universal to the addictive experience as it is only present in certain people who are addicted. Endorphin is an opiate-like chemical and like other opiates is a powerful soother of both emotional and physical pain. It holds a crucial role in infant – mother bonding; known as the chemical of emotion, it is regulated through childhood nurturing and thus its dysregulation is most commonly found in those who have experienced childhood neglect and/or abuse (Maté, 2010). Dysregulation in this system is marked by an inability to self-soothe and create and maintain secure attachments.

The endorphin system regulates through social connection and is compromised by the social contraction or isolation that characterises both the experiences of trauma and addiction. In addiction it can be fed or 'self-medicated' through behaviour like sex when it involves intimacy or through substances like heroin which has been described as 'a warm soft hug' (Maté, 2010).

The three compromised domains are implicated in Paula Hall's (2013) OATs Model (See Fig 3) around the origins of sex addiction, though this theory can be generalised to aid in the

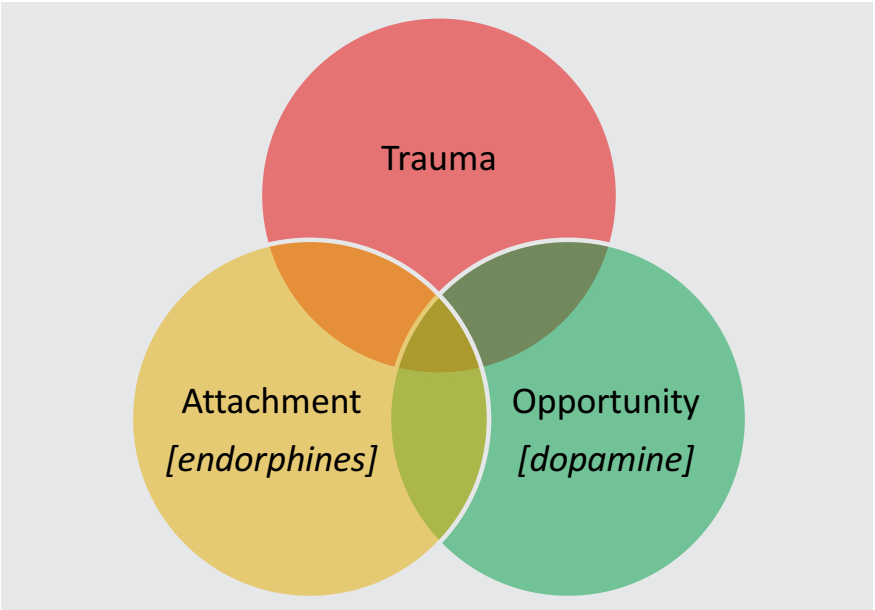

Fig 3: The OATs Model (Paula Hall, 2012 - italics added by author).

The Modulation model offers an elegant understanding of the trauma-addiction interaction and a visual aid in our understanding of the self-medicating nature of addiction.

understanding of any addiction be it acted out through process (behaviour) or substance.

Trauma ultimately erodes resilience and our own sense of self concept. It decreases our feelings of control, our ability to maintain relational connection and to tolerate emotional distress. The Modulation Model (Ogden, Minton & Pain, 2006) offers an elegant depiction of the emotional effects of trauma and how they can be managed through addictive behaviour.

Distress Tolerance

Modulation theory posits that we all have a window of tolerance (See Fig 4), this window is wider for some and narrower for others and that this window signifies the amount of emotional arousal (happy, sad, mad, glad, etc) that we are able to experience comfortably at any given time while the periphery of this window marks the transition of where we will move into states of either hyper (fight/flight) or hypo-arousal (freeze/faint).

Trauma, be it Big 'T' or Small 't' narrows this window resulting in less and less lower and lower levels of arousal launching the person out of their tolerance zone. Addiction to substances or behaviours can be seen as a means of self-medication in order to regulate an individual's levels of arousal with the ultimate goal of re-entering their optimal arousal zone. This is accomplished by using substances or behaviours that sedate (heroin, sleeping tablets,) when one is hyper-aroused and using substances or behaviours that stimulate (gambling, sex, cocaine, speed) as a means of bringing individuals up into our window at times of lethargy and flatness (hypoarousal).

The Modulation model offers an elegant understanding of the trauma-addiction interaction and a visual aid in our understanding of the self-medicating nature of addiction. It outlines a means through which recovery can be achieved through ego strengthening as a means of widening the individual's window.

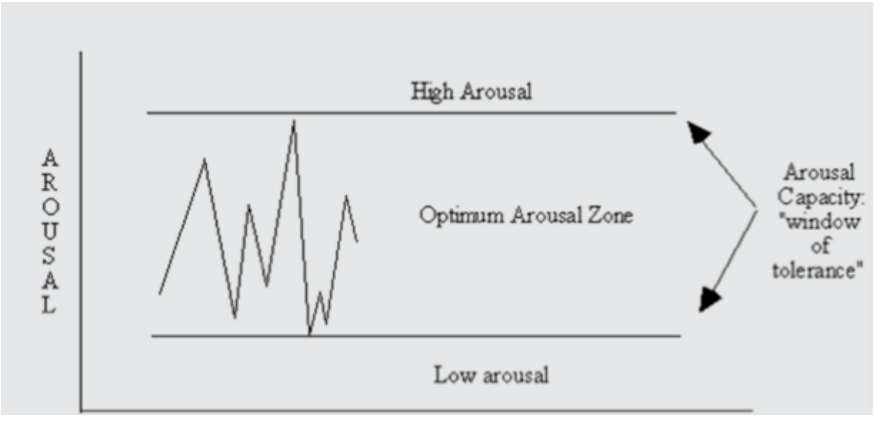

Fig 4: The Modulation Model (Ogden, Minton & Pain, 2006).

Treatment Implications – Affecting Provision

Utilising a trauma lens in in our work with people who experience addictions, while not changing the core philosophies of current treatment approaches, can offer framing, insight and understanding to both the therapist and client insulating against further traumatisation and/or early discharge. Common issues such as those highlighted below can be understood in a newer and more compassionate light.

- Clients presenting as resistant or 'non-compliant' can be re-framed as having underdeveloped coping strategies, retiring and replacing the age-old reference to our clients not having reached rock bottom with a pro-active emphasis on ego-strengthening.

- One can gain greater understanding of power dynamics in the context of trauma symptomology. Given that many traumas often have a theme of one person controlling and having power over another, transference issues can be prevalent and should be expected. In this context power struggles are seen as a client's attempt at establishing control in the therapeutic process, thus creating a felt sense of safety.

- One can expect the re-emergence of trauma symptoms as clients' detox or sample cessation of additive behaviour. Research in this field has not only pointed to this dynamic but notes that paradoxically unless addictive behaviour and co-occuring

trauma are treated together, both abstinence or substance abuse may make trauma symptoms worse. (Najavits, 2002). Early emphasis on ego strengthening through mastering new coping strategies can minimise and even prevent trauma symptom re-emergence.

- High frustration, drama, lethargy, apathy or inflexibility of process in the therapist or agency staff can be explored in the context of vicarious and secondary trauma. Sufficient self-care given the trauma proximity is a priority to ensure emotional safety for the therapist. Strong therapist self-care also models the importance of creating emotional safety to the client.

Treatment Implications – Effective Provision

The utilisation of a trauma lens is not an attempt at offering an alternative model of treatment but instead offering a value-added perspective to the current models being utilised.

Models and therapists wishing to become trauma informed in their interventions and treatment episodes may offer consideration to the addiction recovery process following a similar track and indeed integrating Herman's (1997) trauma recovery process three stage model of Establishing safety, Remembrance & mourning and Reconnecting with and ordinary life:

1. Establishing safety encompasses everything from creating a secure environment, teaching grounding techniques, making efforts to equalise the power dynamic, and many more. It pushes us to understand our client's history and take cognisance of it when examining their and our own interactions. It creates movement from reaction to responsiveness, enabling greater capacity for grounding and reflection through ensuring the pre-frontal cortex remains active and is not hijacked by the reptilian and limbic systems.

2. Remembrance and mourning offers a space to explore what has been lost through traumas and addictions as well as offering the context of how they came to be established in the first instance.

3. Reconnecting with ordinary life marks the understanding of the isolation involved in both the addictive and traumatic experiences, emphasising the need to expand the once contracted social connections and re-enter greater society as an active and equal member. This can be done through a tapering off of therapy, checking in with the client as they establish a life beyond their addiction and also through aftercare services in the context of residential addiction treatment facilities.

Trauma ultimately erodes resilience and our own sense of self concept. It decreases our feelings of control, our ability to maintain relational connection and to tolerate emotional distress.

Conclusion

Despite the evidence of co-occurring trauma in addiction presentations the traditional treatment paradigms both in Ireland and internationally have often chosen to separate trauma treatment from addiction treatment episodes.

Unifying the trauma-addiction dynamic offers a greater biopsychosocial insight into addictive behaviour through an understanding of the underlying biological structures of the brain and hormonal systems which support addictive acting out as well as understanding the adaptive nature of the behaviour itself.

The trauma lens has the potential to add a value added perspective to all humanistic addiction treatment models or ideologies without weakening their theoretical underpinnings. Integrating trauma work into an treatment plan for addictive behaviour, be it in a treatment centre or private therapy room offers a recognition of the individual's journey and an understanding to the predisposing factors that maintain the behaviours. Such understanding can reduce stigma and inform the treatment episode to produce a clearer treatment plan, thus adding clarity for both client and therapist in the creation of a more robust recovery.

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Academic Article

A Simulated Interview with Viktor Frankl: Part 2 - Searching for meaning during times of despair

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

Abstract

Viktor Frankl's approach to psychotherapy embraces some of the most difficult and complex problems encountered throughout life. Unlike many other forms of psychotherapy, Frankl confronts coping with tragic events, often shifting the focus onto meaning and proper attitudes. These notions are reviewed using a simulated interview format.

Throughout his career, Viktor Frankl has made numerous contributions to the field of psychotherapy, with his approach focused on a search for meaning that helps clients triumph over tragedy. Frankl relied on his life experiences to learn, understand, respect, and manage situations that involve pain, tragedy, and death. The present manuscript explores Frankl's ideas with a reliance on his own words, using a simulated dialogue format.

Interview:

The goals of psychotherapy according to Viktor Emil Frankl (VEF) as interviewed by James C. Overholser (JCO)[1].

JCO: Let's get started again. What do you see as the major problems confronting society today?

VEF: "What threatens contemporary man is the alleged meaninglessness of life" (Frankl, 1958, p. 20). "Today, the will to meaning is often frustrated" (Frankl, 1966d, p. 252). "Man is no longer told by drives and instincts what he must do. And in contrast to man in former times, he is no longer told by traditions and values what he should do" (Frankl, 1975, p. 91). "Soon he will not even know what he wants to do" (Frankl, 1963b, p. 27). "In an age of crumbling traditions … ever more people are caught in a feeling of aimlessness and emptiness" (Frankl, 1966b, p. 26).

JCO: How could this come about?

VEF: "Consider today's society: it gratifies and satisfies every need – except for one, the need for meaning" (Frankl, 1978, p. 25). "Ever more people today have the means to live, but no meaning to live for (Frankl, 1978, p. 21). "Our young people are caught in an existential vacuum, an inner void and emptiness" (Frankl, 1969, p. 39).

JCO: I have known people who cope with stress by shopping and buying. How does this style fit with your views?

VEF: "Our industrial society is out to satisfy every need" (Frankl, 1981, p. 77), "and in its desire to increase consumption it often creates needs in order to satisfy them" (Frankl, 1984b, p. 6), "but the most human of all human needs – the need to see a meaning in one's life – remains unsatisfied" (Frankl, 1987, p. 5).

JCO: So is a lack of meaning the primary form of pathology a psychotherapist needs to confront?

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

VEF: "No" (Frankl, 2000, p. 119). "The feeling of meaninglessness is not pathological" (Frankl, 1959, p. 162). "What is sick is not necessarily wrong" (Frankl, 2000, p. 75). "The will to meaning represents not only the most human phenomenon possible, but also that its frustration does not necessarily signify something pathological" (Frankl, 1958b, p. 85). "Man's search for a meaning is … the surest sign of being truly human" (Frankl, 1962b, p. 94).

JCO: Really? But I thought a lack of meaning underlies the sense of despair. How is this not pathological?

VEF: "Despair need not necessarily be pathological" (Frankl, 1958b, p. 84). "Despair is suffering without meaning" (Frankl, 1997a, p. 133). "I can see beyond the misery of the situation to the potential for discovering a meaning behind it, and thus to turn an apparently meaningless life into a genuine human achievement" (Frankl, 1997b, p. 46). "The striving to find a meaning in life is a primary motivational force in man (Frankl, 1967a, p. 20).

JCO: So everyone's life has meaning?

VEF: "Yes, of course" (Frankl, 2000, p. 37). "The so-called life not worth living does not exist" (Frankl, 1958c, p. 36).

JCO: How does a therapist promote meaning in a client's life?

VEF: "In my opinion meaning is something to be found rather than to be given" (Frankl, 1965, p. 57). "It is not the job of a doctor to give meaning to the patient's life. But it may well be his task, through an existential analysis, to enable the patient to find meaning in life" (Frankl, 1967b, p. 141). "Meaning must be found" (Frankl, 2004a, p. 9) "and it must be found by oneself" (Frankl, 1972, p. 88). "It is never up to a therapist to convey to the patient a picture of the world as the therapist sees it, but rather to enable the patient to see the world as it is" (Frankl, 1961b, p. 6). "A psychotherapist … is neither a teacher nor a preacher" (Frankl, 1962c, p. 27). "He resembles an ophthalmologist more than a painter" (Frankl, 1962c, p. 27). "We … broaden his field of vision so that he will become aware of the full spectrum of the possibilities" (Frankl, 2010, p. 89). "The therapist merely assists him in this endeavor" (Frankl, 1960a, p. 11).

JCO: How does all of this work?

VEF: "We … promote the patient to that point where he spontaneously finds meaning" (Frankl, 1966/2016, p. 10). "The more one is immersed and absorbed in something or someone other than oneself the more he really becomes himself" (Frankl, 1975a p. 79). "Only as man withdraws from himself in the sense of releasing self-centered interest and attention will he gain an authentic mode of existence" (Frankl, 1960a, p. 13).

JCO: So a person should aim for self-actualization?

VEF: "Actually, man's concern is not to fulfill himself or to actualize himself, but to fulfill meaning and to realize value" (Frankl, 1959, p. 160). "The more one is immersed and absorbed in something or someone other than oneself the more he really becomes himself" (Frankl, 1975, p. 79).

JCO: In your opinion, what is the best pathway to find meaning?

VEF: "We may find meaning in our lives through deed, through work, through achievement and accomplishment, through creativity" (Frankl, 1968b, p. 11). "Most important, however, is … that of attitudes" (Frankl, 1980, p. 8). "If we cannot change a situation that causes our suffering, we can still choose our attitude" (Frankl, 1980, p. 8).

JCO: In your view, how can therapy help clients to battle their depression?

VEF: "Man yearns for a reason to be happy" (Frankl, 1968b, p. 9). "If man can find and fulfill a meaning in his life he becomes happy" (Frankl, 2004b, p. 94).

JCO: But today, unemployment rates are high, clients are struggling financially, and many people suffer from depression.

VEF: "Depression does not entirely depend on whether people are employed or not, but rather on whether they consider their lives meaningful or not" (Frankl, 1984b, p. 6). "There is also an existential emptiness, and this we find in people with work and without work, in spite of work, and sometimes even because of work" (Frankl, 1984b, p. 6).

JCO: Really? Emptiness continues despite successful employment?

VEF: "It is possible to be caught in existential despair despite full success" (Frankl, 2010, p. 148). "In 'Executive's Disease' the frustrated will to meaning is vicariously compensated by the will to power" (Frankl, 1967a, p. 125). "In addition to this" (Frankl, 1967a, p. 43) "the Sunday neurosis … when the rush of the busy week stops on Sunday and the void

within them suddenly becomes manifest" (Frankl, 1967a, p. 125). "Not only during leisure but also in old age, man is faced with the problem of how he should fill up his time" (Frankl, 2010, p. 87).

JCO: So you feel the core problem in most cases of depression is a lack of meaning?

VEF: "Correct" (Frankl, 2000, p. 51). "Suicide proneness, violent behavior, and drug dependency, are, in fact, due to a lack, or loss, of meaning" (Frankl, 2010, p. 203).

JCO: What about other problems? Many clients struggle because of trauma and other major life events.

VEF: "Pain, death, and guilt are inescapable; the more the neurotic tries to deny them, the more he entangles himself in additional suffering" (Frankl, 1967a, p. 88). "Even if we are the helpless victims of a hopeless situation, facing a fate that cannot be changed, we may rise above ourselves, grow beyond ourselves, and by so doing change ourselves. We may turn a personal tragedy into a triumph" (Frankl, 1980, p. 8).

JCO: Some behavioral strategies argue that clients can combat their depression by engaging in pleasant activities each day.

VEF: "That is not true" (Frankl, 1966/2016, p. 8). "It is the very pursuit of happiness that thwarts happiness" (Frankl, 1975, p. 85). "It is also similar to sleep: if a person is bodily and mentally relaxed he falls asleep automatically. If, however, he tensely and forcibly seeks sleep, this very tenseness makes any relaxation impossible, and consequently there can be no sleep" (Frankl, 1952, p. 128). "The pursuit of happiness is self-defeating … What man actually is concerned with is to have a reason to be happy" (Frankl, 1968b, p. 9).

JCO: I am confused. How does it work?

VEF: "I cannot explain it" (Frankl, 1966/2016, p. 9). "Pleasure is never the goal of striving, but only the effect which results when the striving obtains the desired goal" (Frankl, 1952, p. 128). "The more one aims at pleasure, the more his aim is missed" (Frankl, 1966a, p. 98). "Pleasure … must remain, a side-effect, or by-product, of attaining a goal" (Frankl, 1966a, p. 98). "The harder a man tries to evade unpleasure, or suffering, the deeper he plunges himself into additional suffering" (Frankl, 1967a, p. 127).

JCO: So can we just say that happiness happens?

VEF: "Marvelous! That's a good idea, not simplistic, but as simple as truth allows" (Frankl, 1969, p. 38). "Success and happiness must happen, and the less one cares for them, the more they can" (Frankl, 1988, p. 35). "The more one tries to gain pleasure, the less one is able to obtain it" (Frankl, 1966d, p. 253).

JCO: So what should a therapist do to help clients who are feeling overwhelmed by problems? Is Logotherapy the best approach?

VEF: "I do not wish to convey the impression that beneficial results were always obtained" (Frankl, 1960b, p. 527). "Logotherapy is not a panacea … it is justified to combine logotherapy with other methods" (Frankl, 1967c, p. 150).

JCO: So you believe that attitude changes provide the key to effective therapy?

VEF: "Right" (Frankl, 1971a, p. 310). "Even the negative, the tragic aspects of human existence … may be turned into something positive, something creative" (Frankl, 1972, p. 88).

JCO: What about something extreme, like when a young person dies?

VEF: "Life's transitoriness does not in the least detract from its meaningfulness" (Frankl, 2010, p. 118). "We cannot, after all, judge a biography by its length, by the number of pages in it; we must judge by the richness of the contents (Frankl, 1955a, p. 53). "If life is meaningful, then it is so whether it is long or short" (Frankl, 1958c, p. 33).

JCO: So even when a life has been cut short, it can be important and meaningful?

VEF: "Right" (Frankl, 1990, p. 10). "If life is meaningful, then it is so whether it is long or short" (Frankl, 1967a, p. 128). "Death … does not cancel the meaning of life but rather is the very factor that constitutes its meaning" (Frankl, 1955a, p. 56). "Consider a movie: it consists of thousands upon thousands of individual pictures, and each of them makes sense and carries a meaning, yet the meaning of the whole film cannot be seen before its last sequence is shown" (Frankl, 1997a). "As the end belongs to the story, so death belongs to life" (Frankl, 1967a, p. 128). "Life has a meaning to the last breath" (Frankl, 1954, p. 976).

JCO: And therefore we all must learn how to deal with pain, death and suffering?

VEF: "Suffering is an ineradicable part of life" (Frankl, 1984a, p. 88). "When a man finds that it

is his destiny to suffer, … his unique opportunity lies in the way in which he bears his burden" (Frankl, 1984a, p. 99). "If there is a meaning in life at all, then there must be a meaning in suffering (Frankl, 1968a, p. 5).

JCO: So stress, conflict, and problems can be good things?

VEF: "You are right" (Frankl, 2010, p. 155).

JCO: So problems and struggles can be good because they test your character and make you stronger?

VEF: "Exactly!" (Frankl, in Scully, 1995, p. 4). "Stress is by no means always and necessarily pathogenic or disease producing" (Frankl, 2010, p. 222). "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. 112). "Mental health is based on a certain degree of tension, the tension between what one has already achieved and what he still ought to accomplish, or the gap between what he is and what he should become" (Frankl, 2010, p. 63).

JCO: How do you help clients adjust to pain, loss and mortality?

VEF: "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, 1967c, p. 144).

JCO: How does a person develop the 'right' attitude?

VEF: "Suffering ceases to be suffering at the moment it finds a meaning (Frankl, 1984a, p. 135). "Man's main concern is not to gain pleasure or to avoid pain but rather to see a meaning in his life" (Frankl, 1984a, p. 136).

JCO: How can adversity be a good thing?

VEF: "Life becomes all the more meaningful the more difficult it gets " (Frankl, 1955a, p. 43). "The art of the sailor is his ability to use the wind in order to be driven in a given direction so that he is able to sail even against the wind" (Frankl, 1955a, p. 69). "Just as a small fire is extinguished by the storm while a large fire is enhanced by it – likewise a weak faith is weakened by predicaments and catastrophes, whereas a strong faith is strengthened by them" (Frankl, 1997a, p. 19).

JCO: Most people fear death and become quite upset when a loved one dies. What is your view about death and mortality?

VEF: "The fear of aging and dying is pervasive in the present culture" (Frankl, 2010, p. 118). "In some respects it is death itself that makes life meaningful" (Frankl, 2000, p. 29). "We do an injustice to death by believing that it deprives and robs life of meaning" (Frankl, 1990, p. 8).

JCO: but doesn't the ever-present threat of death have a harmful effect on people?

VEF: "In every moment the human person is steadily molding and forging his own character" (Frankl, 1961a, p. 7). "The essential transitoriness of human existence itself adds to life's meaningfulness. If man were immortal, he would be justified in delaying everything: there would be no need to do anything right now" (Frankl, 1971a, p. 307). "Only under the threat and pressure of death does it make sense to do what we can and should, right now" (Frankl, 1990, p. 7). "Man resembles a sculptor who chisels and hammers the unshaped stone so that the material takes on more and more form … he attempts to 'hammer out' the values in his life …the sculptor has a limited span of time at his disposal for completing his work of art – but that he is not informed when his deadline is" (Frankl, 1955a, p. 53).

JCO: So we create our identity through our daily actions?

VEF: You are right" (Frankl, 2010, p. 155). "Our answer must consist, not in talk and meditation, but in right action" (Frankl, 1984, p. 98). "Man not only behaves according to what he is, he also becomes what he is according to how he behaves" (Frankl, 1967a, p. 35). "What he becomes – within the limits of endowment and environment – he has made himself" (Frankl, 1967a, p. 35). "One's own life is the answer to the question of the meaning of life" (Frankl, 2010, p. 46).

JCO: We might want to take another break. Would that be okay?

VEF: "Of course" (Frankl, 1974, p. 10).

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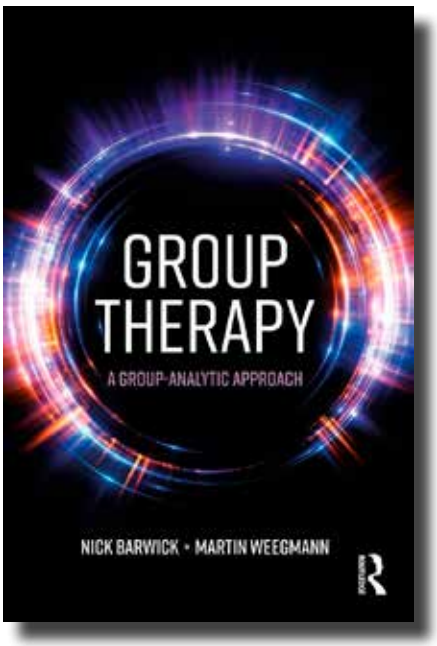
Book Review

Title: *Group Therapy: A Group-Analytic Approach*
Author: *Nick Barwick and Martin Weegman*
Published: *2018*
ISBN: *978-1-138-88970-5*
Reviewed by: *Allyson Coogan*

When was the last time you facilitated a psychotherapeutic group? If you are like most counsellors and psychotherapists practicing in Ireland, you concentrate your efforts on individual clients, perhaps a few couples, and maybe an occasional psycho-educational presentation where you teach assertive communication skills, stress management, or mindfulness techniques for good measure. But what about the process-oriented group work that brings people together; the type of group where members allow their self-protective personas to drop away, freeing-up all those dark and damaging instincts?



If you find the prospect of such a group exhilarating yet daunting, then 'Group therapy: A Group-Analytic Approach,' is a must read. With each paragraph, the authors provide a thorough overview of the basic assumptions underpinning group-analytic psychotherapy, and the work is peppered with extensive descriptions of actual group interactions. The authors graciously share their therapeutic missteps and mistakes, as well as highlighting successes.

Starting with the opening pages, the book sets the stage by placing individual distress within the wider social environment. Through a psycho-social-educational experience, group-analytic therapy aims to engage the individual group members in a personal experience of growth and development that is also collective and political. The concept of interconnectedness, that matrix of associations and networks brought from the individual group members' original group (the family), intermixes with the personal matrices of the other members to form a new matrix so that the personal is also collective.

From our first experience of group within our own families, we are both individual and part-of at the same time, and when seen as a microcosm of society, the group is both the place where pathologies develop and where these same pathologies can be transformed and rehabilitated. As many experienced group therapists know, individuals begin group therapy with the distorted thought that their problems are idiosyncratic and distinct. By being part of a group, the loneliness and isolation brought about by their foibles and imperfections can be alleviated and replaced by a vibrancy and connection with other equally imperfect humans. Group is a place where my faults and shortcomings meet your faults and shortcomings with the result that we are no longer two solitary and forlorn entities, but rather interconnected parts of a greater system. Thus, therapy happens by the group, of the group.

For those new to group therapy, the authors provide a thorough grounding in the core concepts, including slow open and time-limited groups; stranger groups where the members do not violate the sanctity of the group by engaging outside of the group setting; as well as process dynamics such as resonance, amplification and the socialising process.

The sections devoted to clinical discussion between Weegmann and Barwick were a real pleasure to read. Like eavesdropping on two master therapists, the dialogue was inviting and vivid; where the wisdom of the authors was given freely to the reader.

While reading 'Group therapy: A Group-Analytic Approach,' I felt myself become immersed in the lives of the members and the interactions taking place – it was as if the words on the page were so inviting that the group unfolded before my eyes. Reflecting on this, I also identified with, and appreciated, the authors' openness about the experience of facilitating a group. No longer did I feel so alone in my self-doubt and humanness as a group leader.