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- A Simulated Interview with Viktor Frankl: Part 1 - Freedom & Responsibility
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Autonomy

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Contents

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From the Editor:

Welcome to flight IJCP 2018–1. Today, we're exploring Autonomy. It's a place where respect and freedom of choice abound. It recently featured as our first principle in the revised IACP Code of Ethics (IACP, 2018), and even if it's familiar to you already, we think it's worth revisiting. "The end of all our exploring will be to arrive where we started and know the place for the first time" (Eliot, 1943). So here's the flight plan.

Our first article by Maurice Kinsella argues that Autonomy is located at the epicentre of counselling and psychotherapy, and that a sense of egalitarianism in the therapy relationship is what helps it to flourish. He makes four recommendations to assist practitioners in establishing an egalitarian dialogue in order to arrive at Autonomy. His article brings us back to first principles but with a new and more sophisticated appreciation than we had before.

Our second article is "A simulated interview with Viktor Frankl: Part 1 - Freedom and Responsibility" by James C. Overholser. This cleverly assembled work (one of a three part series which we intend to continue in future editions of our journal) uses a novel technique to formulate Frankl's writings and ideas into conversational form. It re-visits Frankl's vision for psychotherapy and his wish to assist people adjusting to tragedy and loss. Frankl demonstrates a strong faith in the power of the mind and the importance of attitude and autonomy. The fact that he qualified as a pilot at age 67 is certainly testament to his outlook on life.

Autonomy begins to develop early in childhood, being the second of Erik Erikson's development stages (Erickson, 1994). Therapists must learn to recognise early trauma and its lingering effects on such early development. Adoption may be one such trauma, argues Patricia Losty in our third article. She looks at adoptions possible impact on an adoptee's development, then examines the perspectives of adoptive parents and birth parents aswell.

Our fourth and final article is "A Conversation on DSM V and its Usefulness in Counselling and Psychotherapy" by Eugene McHugh. While aware of the dual risks to the client (of losing autonomy in the context of a prescriptive model and of being labelled rather than met as a person) Eugene believes on balance that DSM V is a worthwhile tool in Counselling and Psychotherapy. He justifies this on the basis of its facilitation of a clear and common language leading to a more integrated multi-disciplinary approach for the client. The DSM is certainly a reliable topic for creating debate.. reference Éisteach Spring 2016 and the letters page of Éisteach Summer 2016 .. and debate is something of which we would like to see more.

When you fly a plane, you have the benefit of seeing the big picture of whats going on at ground level. In counselling and psychotherapy, there's a lot happening. Mental health continues to gain importance in public consciousness, but it seems we professionals have some issues of our own. The long ongoing legislative move to include Counsellors and Psychotherapists within the remit of the Health and Social Care Professionals Act 2005 is highlighting these issues. The act intends to place us under the jurisdiction of CORU, the body defined by that legislation to oversee registration, conduct, discipline and practice oversight, which will include overseeing qualifications and course provision. Everybody in the profession needs to pay attention. They should be familiar with CORUs Response to Minister for Health on Regulation of

Counsellors and Psychotherapists (see references), which paints an interesting and disparate picture of us as 5000 practitioners across 25 subgroups. Its an aerial view from a third party which highlights insuffient integration and common purpose on the ground. Our professional titles are being defined, the number of professions, our qualification criteria and requirements, our grandparenting rules, our relationship to other professionals, our registration processes. It's a young profession, admittedly, but this is maturation time, we must speak up, listen up and integrate our wish for autonomy with something even more evolved - interdependence.

We want as the editorial team of IJCP that your journal should reflect the various views within the IACP at this time. Afterall, the IACP holds approximately 70% of practitioners. Our editorial team would really encourage you to engage with these issues through our "Letters To The Editor" page so that the national debate is reflected in your journal. The team always welcome your input if you have ideas for improving your journal. In line with our call to action in Eisteach's Winter 2016 editorial, we want to honour Carl Berkeley's founding vision of the magazine being a sounding board for members. Let's hear from you, whatever it is you want to voice! This plane wants to be in regular touch with ground control, always part of the professional conversation.

Before we sign off, we want to wholeheartedly thank Donna Bacon who has recently retired from the editorial team and to welcome Allyson Coogan who is stepping on board. Allyson hails from Canada and has recently moved to Ireland bringing a wealth of resources and a fresh perspective to this position. This includes experience as the editor of the psychology newsletter at McGill University, and as community mental health correspondent for the Northern Sun News.

Bon Voyage from IJCP 2018–1 and lets hear from you in the next few months. For now, just sit back, relax and enjoy your flight.

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Hugh Morley
on behalf of the Editorial Committee
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Academic Article

Egalitarianism in Therapeutic Dialogue: A Catalyst for Client Autonomy

By Maurice Kinsella

Introduction

Autonomy sits at the epicentre of counselling and psychotherapy. As a client capacity that practitioners have a duty to uphold and as a destination that they actively pursue with clients, autonomy pervades the ethical concerns that underscore therapeutic principles and practices. Engagement in "dialogue" (i.e. each person being responsively attuned to what emerges within the therapeutic encounter) is a catalyst in fostering such autonomy. Dialogue is most fully realised when it emerges within an "egalitarian" dyad grounded in a recognition of clients' nascent autonomy and their ability to operate as a co-directive force in their therapeutic journey.

Implementing an egalitarian dialogue can be challenging – in particular in scenarios where a client's autonomy may have been previously undermined. In this case, they may benefit from a greater use of "paternalistic" interventions e.g. in early-stage addiction rehabilitation. Nevertheless, dialogue is foundational to both the establishment of a robust therapeutic alliance and to the joint-achievement of therapeutic goals. Building on insights from the field of "relational autonomy", this paper makes four recommendations that can act as a useful reflective device for practitioners seeking to foster egalitarian dialogue.

Dialogical Personhood and the Therapeutic Alliance

People are inherently dialogical. Interpersonal relationships are a prime agent in facilitating the ongoing process of psychological maturation – helping to mould the clay of who we are and the attributes that we possess. The ever-evolving social matrix within which we live our lives is internalised over time, profoundly and pervasively influencing facets of personal identity such as beliefs, desires, and goals.

Building on the belief that "… we define our identity always in dialogue with, sometimes in struggle against, the things our significant others want to see in us" (Taylor, 1992, p. 33) , interpersonal relationships can be a means through which our autonomous capacities are either affirmed or undermined. As Catriona MacKenzie (2008) discusses, the

Therapeutic dialogue represents a process of mutual exchange and understanding: expressing "me" and internalising "you", so that "we" may responsively negotiate the shared meaning of the encounter.

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experience of trust we have in our inner resources has both "first-personal" and "relational" aspects and is navigated within a pattern of *call-and-response* with others. There are few places in which this process is more apparent than in counselling and psychotherapy, wherein the therapeutic alliance can enable clients to attain greater psychological health and to achieve the aligned ability to exercise positive changes in their life. This alliance can be understood as the client and counsellor's subjective experience of working together towards psychotherapeutic goals, including the experience of an interpersonal bond (Duff & Bedi, 2010). It is characterized by experiences such as "mutual trust, respect and understanding" (Christman, 2013, p. 378).

A prime catalyst engendering the transformative power of this alliance is the establishment of dialogue. Therapeutic dialogue represents a process of mutual exchange and understanding: expressing "me" and internalising "you", so that "we" may responsively negotiate the shared meaning of the encounter. The concept of "catalysed" (developed from insights within Self-Determination Theory) conveys the stance that autonomy is not necessarily *created* by the experience of interpersonal recognition within dialogue, but rather – as an inherent capacity – is *fostered* by this experience.

The distinctly therapeutic nature of this dialogue is that it occurs to facilitate clients' healthy psychological development. It therefore calls on practitioners to be mindful of the nuances of their interactions in a manner that may be more demanding than other dialogues they encounter in their lives. Given the elevated vulnerabilities with which clients may present, they can be especially perceptive of interpersonal dynamics that occur within the therapeutic dyad and sensitive to them. Practitioners will, here, be familiar with the three core therapeutic conditions that underscore Carl Rogers' "Person-centred Therapy" (1995 (1961)) – namely empathy, congruence and unconditional positive regard.

Autonomy within Counselling: A Relational Perspective

Autonomy is understood within philosophical literature as "self-law" (*auto-nomos*): the iteratively realised capacity to govern one's life in accordance with justifications and motivations that are authentically one's own, rather than the product of external forces deemed manipulative or distorting (Christman, 2015). The value of autonomy in terms of one's psychological wellbeing is attested to within numerous contemporary clinical orientations, including Motivational Interviewing (MI) and Self-Determination Theory (SDT). Here, SDT provides a further definition of autonomy as the "self-endorsement of one's behaviour and the accompanying sense of volition or willingness" (Ryan & Deci, 2008, pp. 186-187). Engagement in counselling and psychotherapy enables clients to more fully recognise the presence of their autonomous capacities and to exercise such capacities in how they choose to live their life. It is, consequently, no surprise that autonomy is positioned as a prominent conceptual pillar within bioethical literature. Here, it is vital in defining the rights of clients and the attendant responsibilities of practitioners to uphold such rights, as well as in articulating the broader mission of the therapeutic journey.

Codes of ethics within contemporary healthcare are increasingly supportive of professional encounters being more firmly grounded in a "person-to-person" dialogical alliance. These run counter to "practitioner-to-patient" prescriptive monologues that discard discussion and deliberation in place of paternalistic directedness. The rationale behind this movement (within a therapeutic context) is that although the skill-set possessed by a practitioner (rooted for example in their knowledge base or experiential insights) is a necessary feature of their professional competency, it may not be *sufficient*. Instead – as within the Humanistic paradigm – it is argued that the success of one's strategies derives from one's interactional style. This brings the therapeutic bond into completion. In a study undertaken by Jack De Stefano and colleagues (2010), it was reported that clients' attentiveness to practitioners' technical skills was significantly superseded by the value they placed on their "relational persona as the embodiment of desirable human qualities and facilitative communicational skills" (De Stefano, Mann-Feder, Gazzola, 2010, p. 144). Similarly, for Carlton Duff and Robinder Bedi (2010, p. 91), the experience of an "alliance"

was considered among the most "consistent and robust" predictors of counselling outcomes.

As Carolyn Ells and colleagues (2011) note, the broader bioethical literature is increasingly explicit about recognising and being receptive towards patients' decisional and volitional capacities – as within Tom Beauchamp and James Childress' (2009) analysis. Dissatisfied with models that appear to equate autonomy with independence from others – "the right to make one's own decisions, protected from outside interference" (Kim, 2013, p. 183) – clinical discourse has moved towards alternative encounter models. In particular, the concept of autonomy has been revisited to more fully articulate our social nature and accommodate healthy embeddedness. Here, "embeddedness" can be understood, from a sociological perspective, as "a multidimensional construct relating generally to the importance of social networks for action" (Moody & White, 2003, p. 4). This calls for an ethic of *actively fostering* autonomy through the nature and tone of one's interactions (i.e. upholding clients' "positive" right to a supportive environment), rather than simply passively upholding clients' "negative" right to non-interference.

This movement has emerged alongside the ascendency of "relational" models of autonomy which assert that there is a correlation between the nature of the environments within which people are embedded, and the development and utilisation of their autonomous capacities. Relational perspectives are broadly aligned in the conviction that "persons are socially embedded and that agents' identities are formed within the context of social relationships and shaped by a complex of intersecting social determinants" (MacKenzie & Stoljar, 2000, p. 4). Within a wider healthcare context, as Vikki Entwistle and colleagues (2010, p. 744) note, "all communication with patients" is rendered "potentially significant for their autonomy" . The communication style adopted by the practitioner has consequences both for the interpersonal client-counsellor relationship, and the client's own relationship with themselves.

The therapeutic alliance emerges when both parties come together to create and achieve common therapeutic goals. But what attributes should rightly constitute this alliance?

While the goal of personal therapy may be *individual* autonomy-growth, a dialogical position enables us to more firmly appreciate the extent to which this process is most fully facilitated through a healthy therapeutic *relationship* grounded in the practitioner's recognition of the client's capacity for autonomy. Fostering autonomy should not be regarded as an individualistic endeavour, but as a co-journeying, where "…part of the mechanism for achieving such a renewed self-understanding is aid and understanding from significant others and social agencies" (Christman, 2013, p.378). As Stefaan Cuypers (2001, p. 55) argues, individualistic models of autonomy are "directly at odds with our intuitive, common sense conception of the nature of persons".

Both MI and SDT have attempted to empirically validate this perspective, in particular within the field of addiction rehabilitative practice. These approaches argue that the greater the degree to which clients' actions are rooted in an experience of autonomous choice, the more likely clients are to both commence and persevere through rehabilitation (DiClemente, Bellino & Neavins, 1999; Ryan, Lynch, Vansteenkist & Deci, 2011). Practitioners are therefore encouraged to provide "autonomy support ", defined as the extent to which clients feel supported in their ability to function autonomously and make decisions congruent with their sense of self (Kasser & Ryan, 1999). Building on this relational stance, SDT contends that the individual's inherent tendencies towards personal growth and integrated functioning require a nurturing environment (Deci, 1975; Deci & Vansteenkiste, 2004; Ryan & Deci, 2000). A crucial means of mobilising clients' intrinsic values and stimulating behaviour change (Miller, Moyers, Ernst & Amrhein, 2008) is therefore through establishing a collaborative dynamic. This reduces the power-disparity that may undermine clients' commitment to and cooperation with the therapeutic journey. In such instances, therapeutic interactions are designed to facilitate clients' understanding of the therapeutic process , their role within it, and how best to take ownership of it.

Therapeutic Egalitarianism and its Dialogical Rootedness

The therapeutic alliance emerges when both parties come together to create and achieve common therapeutic goals. But what attributes should rightly constitute this alliance? As discussed, paternalistic stances may perpetuate an image of practitioners as the *sole* causal agent of change, therefore

Power differentials are a lived reality of therapeutic encounters that shape peoples' approach to the dyad and the role they occupy within it.

undermining clients' self-directedness. In their place, we are offered models that are premised on supporting an egalitarian form of clinical interaction (Caplan, 2008). At the heart of this move is the belief that, when possible, clients' decisional and volitional capacities should be both recognised and encouraged as being a directive force in their therapeutic journey. This imbues a more authentic and efficacious engagement.

Calls for the therapeutic alliance to be grounded in such equality require us to ask "equality of *what*?". At first glance, there are a number of indications that inequalities pervade the relationship. The fact that counselling and psychotherapy exists as a profession, with its evidence-based strategies, insights and ethics, attests to this. Alongside this, practitioners are called to display ongoing attentiveness to their emotional and psychological wellbeing, for example to "monitor their own personal functioning and seek help when their personal resources are sufficiently depleted to require such action" (IACP, 2011, 4.1.2). The inference here is that practitioners are often more attuned to the client's psychological needs, and how best to fulfil them, than the clients themselves might be.

This highlights how practitioners operate from a place of an immediate differential, which, in turn, may support the *need* for them to occupy a directive stance within the relationship. Indeed, awareness of such differences is often the key motivator in clients' decisions to seek clinical intervention in the first place. Many codes of ethics e.g. the IACP Code (2011, 4.3.1.) do in fact explicitly acknowledge this disparity, holding that ethical counsellors are "acutely aware of the power dynamics of the practitioner/client relationship and shall not exploit clients in any way, either during the relationship or after its conclusion".

Power differentials are a lived reality of therapeutic encounters that shape peoples' approach to the dyad and the role they occupy within it. Consequently, they should not be disavowed out of hand *per se*, but respected as a defining feature of the relationship to be navigated with cautious consideration. Establishing an egalitarian dialogue is therefore not so much about the denial of practitioners' capacity (and often professional responsibility) to operate in a directive light, but rather about the discretionary use of such direction in a *dialogical* context, so as not to undercut the self-determining capacities of those seeking their professional guidance. The essence of the therapeutic alliance is that it is a collaborative relationship, with both client and practitioner participating, *if in distinct ways*.

Here, we can distinguish between two forms of equality. The first, "ontological equality" (operating in an ethical sphere), affirms each person's rights and the attendant responsibilities to uphold such rights in one's interpersonal interactions. Such equality is a foundational attribute endowed by our shared humanity and exists irrespective of the particular characteristics a person may possess. It is not synonymous with sameness or homogeny, which may undercut our appreciation of each person's individuality, and so it is useful to consider a second form of "discrete equality" (operating in a cognitive/physiological sphere), which affirms the distinctiveness of the attributes each person possesses and allows us to recognise difference in such attributes. Equality in one's rights and dignity does not equate to equality in one's abilities, needs, and vulnerabilities.

Egalitarian dialogue therefore serves a dual function. Firstly, it helps open the door to acknowledging and accommodating the contribution that clients can make to the trajectory of the therapeutic relationship – grounded in the belief that "since clients hold almost all the information about their past and current thoughts, feelings and experiences, it is essential that clients actively participate in the joint search for greater understanding" (Nelson-Jones, 2002, p. 59). Secondly, it serves the role of fostering clients' recognition of *themselves* as a resource in overcoming the challenges they face. Inter-personal recognition of one's autonomous capacities fosters an attendant sense of intra-personal recognition. Susan Sherwin's discussion on "negative stereotypes" explores a corollary of this argument, holding that experiencing "diminished expectations" can develop into "diminished capacities" (McLeod & Sherwin, 2000, p. 79).

It is difficult to sustain the argument that clients can exercise a requisite degree of ownership over their lives following the cessation of therapy, if it is not

preceded by an invitation to develop an acquaintance with whom it is that will exercise such ownership i.e. oneself. Egalitarian encounters thus motivate clients to reflexively endorse their personhood and appreciate themselves beyond the mere moniker of "patient" or "presenting problem", and to utilise this intra-personal insight in a directive capacity within the therapeutic alliance. A clients' phenomenal frame of reference is thus an important resource in helping shape therapy as an endeavour that is at once both more authentic, and attainable.

Egalitarianism in Therapeutic Dialogue

Facilitating an egalitarian dialogue between client and practitioner is a challenging process that requires the ability to make use of one's therapeutic toolkit while accommodating a clients' co-directive role within the dyad. The practitioner's stance influences whether clients will come to understand themselves as either simply submitting to information and instruction (potentially fostering dependence), or as actively collaborating in formulating therapeutic strategies (fostering autonomy). Drawing on clinical insights into therapeutic approaches, in line with Sue Eusden's (2011, p. 112) call for practitioners to become aware and actively foster "the intersubjective, bidirectional nature of the therapeutic alliance", we make four recommendations to assist practitioners in establishing an egalitarian dialogue.

- Differentiating between "ontological" and "discrete" forms of equality helps to maintain a mindfulness that each member of the alliance brings with them a unique set of attributes and occupies a distinctive role within the dyad. This recognition is balanced against an acknowledgement that, irrespective of such differentials, both parties possess an innate dignity that should be respected.

Differentiating between "ontological" and "discrete" forms of equality helps to maintain a mindfulness that each member of the alliance brings with them a unique set of attributes and occupies a distinctive role within the dyad.

- Disavowing unreflective practice ensures that the process of coming to know, understand and empathise with the *person* at the heart of the alliance is not bypassed in favour of engaging with the particular *problem* they are exhibiting. Full appreciation for the issues that clients may present with is attained when they are contextualised within the broader ambit of their own lived experience and their wider life circumstances. This most fully occurs through attentive interpersonal interaction.

- Deliberating on the formulation and realisation of therapeutic goals ensures that clients remain a collaborative participant in the process, someone whose phenomenal frame of reference should be called upon to act as a co-directive force in the trajectory of therapy. This is vital so that the client may look *on* themselves as capable of active participation in the therapeutic encounter and look *to* themselves in scoping the direction of the therapeutic narrative – in particular so that they may continue to grow autonomously following the cessation of therapy.

- Using directive strategies in a discretionary way (in a manner that most suitably addresses clients' needs) is still useful at times. Clients' vulnerabilities may manifest themselves in an inability (perceived or otherwise) to exercise their autonomous capacities, and here, counsellors must occupy a more explicitly paternalistic stance. However, such discretion allows for the use of directive interventions at appropriate times and ensures that clients' own capacities are not habitually crowded-out.

Conclusion

Dialogue lies at the heart of the therapeutic alliance. It is a "two-way communication for good or ill . . . [where] . . . counsellors and clients are in a continuous process of sending, receiving, evaluating and interpreting verbal, vocal and bodily communication" (Nelson-Jones, 2002, p. 53). The process of therapeutic engagement *must* be grounded in an attentiveness to and facilitation of dialogue, given that it has the power to catalyse a client's autonomous capacities. This is what an egalitarian ethic most fully accommodates. It requires an acute mindfulness that the nature and tone of one's interactions can be internalised by clients and cause repercussions throughout their self-system. It obliges practitioners to be aware that power differentials (real

or perceived) exist between client and practitioner, and the quality of the therapeutic encounter depends on how the differentials are handled. Egalitarian dialogue is rooted in the belief that the narrative unfolding in the therapeutic alliance is given its fullest expression through a process of co-authorship between client and practitioner, where both are actively and authentically collaborating .

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Academic Article

A Simulated Interview with Viktor Frankl: Part 1 - Freedom & Responsibility

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

Even while he was imprisoned in the concentration camps, Frankl continued to develop his ideas. His landmark books ... captured the agony experienced by these prisoners on a daily basis, and how these horrific events changed Frankl's views of life forever.

Introduction

Viktor Frankl developed a vision for psychotherapy that embraces broad issues relevant to life and death decisions. Derived from his time spent imprisoned in concentration camps, Frankl developed a vision for helping people adjust to tragedy and loss. Frankl argued against the immutable power of genetics or environmental influences, favoring the power of the mind and the importance of a person's attitude. The present manuscript examines many ideas described throughout Frankl's career, using a simulated interview to capture these ideas in dialogue form.

Throughout his career, Viktor Frankl has made numerous contributions to the field of psychotherapy, promoting an existential view that confronts the meaning in life. Viktor Frankl was born in Vienna on March 26, 1905, and he died September 2, 1997. He lived most of his life in Vienna, Austria, near the historic homes of Sigmund Freud and Alfred Adler. Frankl studied medicine and earned his MD in 1930, specializing in neurology and psychiatry. After the war, in 1949, he went on to earn a Ph.D. in philosophy with a focus on psychology and religion. Before the start of World War II, Frankl began practicing psychiatry in the shadows of Nazi Germany. Being raised Jewish, this was a tense time for Frankl and his family, as well as most people throughout Europe. Nazi soldiers moved into Vienna in 1938, and on September 25, 1942, Frankl was deported to the Nazi concentration camp at Auschwitz. He spent three years in four different concentration camps, and was released in 1945. He went on to publish numerous books and journal articles that explained how these horrific experiences had shaped his personal and professional views.

Even while he was imprisoned in the concentration camps, Frankl continued to develop his ideas. His landmark books "Man's Search for Meaning" and "The Doctor and the Soul" captured the agony experienced by these prisoners on a daily basis, and how these horrific events changed Frankl's views of life forever. Throughout the rest of his career, Frankl campaigned against hate and terrorism, and shared his existential perspective. According to Frankl's view of psychotherapy, an assortment of problems arise from the changes

I had to go through the hell of despair over the apparent meaninglessness of life, through total and ultimate nihilism

that pervade modern society. Frankl encouraged clients to focus on the major aspects of life, death, freedom, and responsibility. He has emphasized the value of searching for each individual's personal meaning in life, and creating a life worth living.

There is a risk that Frankl's original words and ideas may be neglected in graduate training today. The thoughts and words from several other pioneers in psychotherapy have been captured in real interviews with Albert Ellis (Overholser, 2003) and Irvin Yalom (Overholser, 2005) as well as simulated interviews with Carl Rogers (Overholser, 2007) and Alfred Adler (Overholser, 2010; 2013). It remains important to respect the life and career of these experts, valuing the lessons they have learned and shared through their published works. These pioneers represent the legacy of our field. The present manuscript provides a condensed summary of the words and ideas behind Viktor Frankl's existential ideology, presented in the format of a simulated interview.

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

Interview:
An exploration of the existential views of Viktor Emil Frankl (VEF) interviewed by James C. Overholser (JCO).

JCO: I have found your writings to be quite inspirational. Thank you for meeting with me. You have written about your experiences during World War II. Maybe you can share how those experiences shaped your life as well as your career.

VEF: "I am a survivor of four camps, that is, concentration camps" (Frankl, 1965, p. 54). "I spent a total of three years in four camps" (Frankl, 2000, p. 98).

JCO: How did the war affect you and your family?

VEF: "I had to go through the hell of despair over the apparent meaninglessness of life, through total and ultimate nihilism" (Frankl, 1981, p. 77). "My father died in Theresienstadt practically in my arms. My mother died in the gas chambers of Auschwitz. My brother, so I was told, perished in a mine of one of the branch camps of Auschwitz" (Frankl, 2000, p. 100). "I did not know whether my wife was alive, and I had no means of finding out" (Frankl, 1992, p. 50). "I learned that Tilly had died with many others after the liberation of Bergen-Belsen" (Frankl, 2000, p. 91).

JCO: I am sorry to hear about these events. What was your experience like, surviving the concentration camps?

VEF: "We were cold and hungry, and there was not enough room for everyone to squat on the bare ground, let alone lie down. One five-ounce piece of bread was our only food in four days" (Frankl, 1992, p. 24). "Beatings occurred on the slightest provocation, sometimes for no reason at all" (Frankl, 1992, p. 36).

JCO: What impact did these events have on you?

VEF: "No dream, no matter how horrible, could be as bad as the reality that surrounded us" (Frankl, 1984a, p. 48). "We looked like skeletons disguised with skin and rags" (Frankl, 1984a, p. 49). "Life in a concentration camp tore open the human soul and exposed its depths (Frankl, 1984a, p. 108). "The thought of suicide was entertained by nearly everyone, if only for a brief time. It was born of the hopelessness of the situation, the constant danger looming over us daily and hourly, and the closeness of the deaths suffered by many of the others" (Frankl, 1992, p. 31).

JCO: These experiences sound horrific. How did you get through years in these horrific conditions?

VEF: "Through the right attitude" (Frankl, 1971a, p. 308). "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 unchangeable suffering is transmuted into a heroic and victorious achievement" (Frankl, 1971a, p. 308).

JCO: How did your time spent in the concentration camps influence your vision for psychotherapy?

VEF: "It is necessary to supplement psychotherapy by a

new procedure" (Frankl, 1956b, p. 60). "Logotherapy is that therapy centering on life's meaning as well as man's search for this meaning" (Frankl, 1962b, p. 95). "In every case man retains the freedom and the possibility of deciding for or against the influence of his surroundings" (Frankl, 1955a, p. 79). "Every human being has the freedom to change at any instant" (Frankl, 2010, p. 66).

JCO: So you believe that there are options even in extreme conditions when problems appear overwhelming?

VEF: "Of course" (Frankl, 1961b, p. 5). "The first tenet of logotherapy is freedom of will" (Frankl, 1968b, p. 8). "The freedom to take a stand toward conditions" (Frankl, 1968b, p. 8).

JCO: But in some situations, a person has no other option, no way out, nothing they can possibly do to change a bad situation.

VEF: "'How can you say such a thing'" (Frankl, 2000, p. 39). "Man's freedom is a finite freedom, not freedom from conditions; his freedom lies in the potentiality for taking a stand toward whatever conditions might confront him" (Frankl, 1966/2016, p. 11). "Logotherapy assumes that man's mind is free to make choices." (Frankl, 1966, p. 361). "There are always choices to make, every day, every hour" (Frankl, 1968a, p. 7). "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, 1967, p. 141). "Do you agree?" (Frankl, 1955a, p. 192).

JCO: Okay, I agree. I often tell people that if they can change their attitude, they can change their life.

VEF: "Exactly!" (Frankl, 1969, p. 34). "If we cannot change a situation that causes our suffering, we still can choose our attitude" (Frankl, 1980, p. 8). "Man always retains the capacity to take a stand toward whatever conditions he may have to face" (Frankl, 1968b, p. 8). "Man's inner strength may raise him above his outward fate" (Frankl, 1968a, p. 7). "Everything can be taken from a man but one thing: the last of the human freedoms – to choose one's attitude in any given set of circumstances, to choose one's own way (Frankl, 1984a, p. 86). "If we cannot change a situation that causes our suffering, we still can choose our attitude" (Frankl, 1980, p. 8). "Where we can no longer control our fate and reshape it, we must be able to accept it" (Frankl, 1958, p. 32).

JCO: I would expect that life in a concentration camp would drag everyone down to their lowest point.

VEF: "This is not true" (Frankl, 2010, p. 151). "The sort of person the prisoner became was the result of an inner decision, and not the result of camp influences alone" (Frankl, 1968a, p. 6). "We who lived in concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread" (Frankl, 1968a, pp. 5-6)."Faced with the identical situation, one man became a swine while the other attained almost saintly status" (Frankl, 1955b, p. 24). "Man has both potentialities within himself; which one is actualized, depends on decisions but not on conditions" (Frankl, 1962a, p. 118).

JCO: So you feel that humans have potential for both good and for evil?

Heredity is no more than the material from which man builds himself. It is no more than the stones that are, or are not, refused and rejected by the builder. But the builder is not built of stonesx

VEF: "Man is ultimately self-determining. What he becomes he has made out of himself" (Frankl, 1962a, p. 118). "Any man can, even under such circumstances, decide what shall become of him – mentally and spiritually (Frankl, 1984a, p. 87). "Man is free to choose his attitude in any given situation" (Frankl, 1968b, p. 8).

JCO: But don't you feel that we are all created by some mix of genetics and environment?

VEF: "This is not true" (Frankl, 1966/2016, p. 8). "Man is by no means a product of inheritance and environment" (Frankl, 1955b, p. 24). "Heredity is no more than the material from which man builds himself. It is no more than the stones that are, or are not, refused and rejected by the builder. But the builder is not built of stones"

Those most apt to survive the camps were those oriented toward the future – toward a task, or a person, waiting for them in the future, toward a meaning to be fulfilled by them in the future

(Frankl, 1971b, p. 26). "In every moment, the human person is steadily molding and forging his own character" (Frankl, 1961a, p. 7). "The conditions do not determine me but I determine whether I yield to them or brave them" (Frankl, 1961a, p. 6). "The son of the drunkard need not become a drunkard himself" (Frankl, 1962a, p. 117).

JCO: But there is such an emphasis today on biological factors and genetics research.

VEF: "Do you see what is at stake here?" (Frankl, 1984b, p. 6). "We only have to remember how the conception of man as 'nothing but' the product of heredity and environment … pushed us all into historical disasters" (Frankl, 1958, p. 35). "The gas chambers of Auschwitz, that was the ultimate consequence of the theory that man is nothing but a product of inheritance and environment" (Frankl, 1955b, p. 26).

JCO: Thankfully, the concentration camps have been closed for many years. What advice would you share with someone who is struggling to endure extremely harsh negative life events?

VEF: "There is … the possibility of finding meaning even in an inescapable, hopeless situation. By the very stand we take toward such a predicament, we may rise above it, transform it into an achievement. In this way, the tragic aspects of life may be turned into something positive" (Frankl, 1968b, p. 11).

JCO: How do we accomplish this goal?

VEF: "Those most apt to survive the camps were those oriented toward the future – toward a task,

Man not only behaves according to what he is, but also becomes what he is according to how he behaves

or a person, waiting for them in the future, toward a meaning to be fulfilled by them in the future" (Frankl, 1978, p. 37).

JCO: They must have been uplifting to others.

VEF: "Some men lost all hope, but it was the incorrigible optimists who were the most irritating companions" (Frankl, 1984a, p. 53-54).

JCO: So naïve optimism is bad, but realistic hopefulness is helpful. Would you say that your approach to therapy is similar to Rational-Emotive Behavior Therapy?

VEF: "What do you mean by this?" (Frankl, 1963, p. 34).

JCO: Does logotherapy help clients to become more logical by reducing a client's irrational beliefs?

VEF: "It would be a grave mistake … to think that in logotherapy the therapist applies "logic" to the patient – as though he tried 'to talk a patient out' of ideas" (Frankl, 1953, p. 10). "Logotherapy is as far removed from being a process of logical reasoning as from being merely moral exhortation" (Frankl, 1961b, p. 5).

JCO: You call your approach to therapy 'Logotherapy'. What do you mean by that?

VEF: "What do I mean by that?" (Frankl, 1966/2016, p. 10). "For didactic purposes one could define logotherapy by the literal translation as healing through meaning" (Frankl, 1967, p. 140). "'Logos' of course is 'meaning', more specifically, one's personal life task" (Frankl, 1968b, p. 8). "A literal translation of the term 'logotherapy' is 'therapy through meaning' (Frankl, 1978, p. 19).

JCO: So logotherapy helps clients to focus on the important things in life?

VEF: "Yes" (Frankl, 1969, p. 38). "I see the meaning of logotherapy in helping others to see meaning in life (Frankl, 1997, p. 136). "Logotherapy insists that man's main concern is not to seek pleasure or to avoid pain, but rather to find a meaning in his life" (Frankl, 1963, p. 31).

JCO: How much do you feel the therapist should focus on problematic behavior or understanding people?

VEF: "Man not only behaves according to what he is, but also becomes what he is according to how he behaves" (Frankl, 1963, p. 40). "Man is not only responsible for what he does but also for what he is" (Frankl, 1961a, p. 6).

JCO: That is an enigmatic statement. What do you mean by being responsible for what a person is?

VEF: "What do I mean by that?" (Frankl, 2010, p. 152). "A man only could actualize himself by reaching out for a meaning to fulfill or by reaching out for a fellow human being to love" (Frankl, 1969, p. 38). "True human wholeness must include the spiritual as an essential element" (Frankl, 1961c, p. 2).

JCO: Okay. Let's take short break

and we can continue our discussion shortly.

VEF: "Of course" (Frankl, 1961b, p. 5).

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Practitioner Perspective

The Need for Therapists to Gain an Understanding of the Multiple Challenges Involved for Members of the Adoption Triad

Patricia Losty


Photo by: Anthony Losty

Introduction

This article seeks to present an understanding of the multiple and complex ways that adoption impacts all members of the extended family system. Issues such as bonding and attachment problems, identity, issues of loss and grief, search and reunion are central to be addressed in assessing and working with adoptees, birthparents and adoptive parents.

Historically adoption was viewed as a solution to shameful pregnancies and infertility. Thankfully, the more contemporary and realistic view is that adoption is a multigenerational and ongoing process that permanently affects the lives of all involved (Baden, Biafora, Javier and Gingerich 2007).

It is vital for therapists working with the adoption community to be able to acknowledge their client's early trauma and the lingering effects of separation. According to Baden et al, (2007), way too many clients feel they are providing as much help to their therapist with education about adoption issues as they are getting back from their therapist.

The author suggests that, in her experience, of attending adoption training, workshops and conferences, therapists are often underrepresented. This fact only encourages the silence on adoption issues to continue. Adoption also remains a significantly under researched area of inquiry in Ireland. It is only as recent as February 2017 that the government formed a research sub-committee to assist in formulating and enabling research (Irish Adoption Authority, 2017).

While acknowledging that the impact of adoption extends to birth and adoptive siblings, aunts and uncles, grandparents and cousins, this article will focus mainly on the triad.

The Adoptee

'It has been noted by parents and clinicians that many adoptees demonstrate little or no discernible reaction upon being told of their adoption. Might it not be possible this lack of reaction is a result of unconscious awareness of the fact of their adoption on the part of adoptees?'(Verrie 1993, p.7). As an infant does not see him or herself as a separate entity, we must believe that he or she sees themselves as part of the person they were physically attached and bonded to for forty weeks. Through separation from the one thing to which the infant has connected the infant will feel part of his or herself

to be lost. 'When the postnatal bonding period is interrupted by a separation from the biological mother, the resultant experience of abandonment and loss is indelibly imprinted upon the unconscious minds of these children, causing that what I call the "primal wound"(Verrier 1993, p1). The infant will not remember the trauma of this separation but it will stay in the subconscious as he or she has lived it. That the child does not consciously remember it will not diminish the impact of it. According to (Verrier 1993, p9), it has at last begun to be recognised that there is a profound lifelong effect on a person that has been abused in childhood and often requires years of therapy to overcome. Verrier (1993) suggests 'what if the most abusive thing which can happen a child is that he or she is taken from their mother?' It is interesting to note that Nancy Verrier is the mother of an adopted child and also the biological mother of a child.

The adoptee will carry the issue of abandonment into adult life when unexplored in the childhood years. Bowlby (2005) describes a pattern of anxious avoidant attachment in which the individual has no confidence that, when he seeks care, he will find it. The individual attempts to live his life being emotionally self-sufficient. He becomes insecure in all his relationships. He fears every time he gets close to somebody they may abandon him. The adoptee may have been told as a child that he was the (chosen) one. He thinks "yes I was chosen, but first I was rejected". One adoptee writes that her distrust of relationships affected her ability to bond with other children in primary school and on into secondary school. "I began to foster the belief that if I did not let people get to know the real me, they would not be able to reject me or hurt me" (Cashin 2006, p.28).

Silence and secrecy within adoption can also impact on the interpersonal relationships of adult adoptees whereas openness helps in their resolution of adoption-related issues

Many adoptees have feelings of frustration and confusion during these early teenage years. Many deny these feelings. They begin to wonder what would have happened them if their adoptive parents had not "rescued" them from the mother and baby home or orphanage. They start to have self-doubts "was I that bad that my biological mother felt she had to give me away?" In order not to seem ungrateful to their adoptive parents, they suppress these feelings. However, the memories of the trauma of a chaotic pregnancy and a separation from the mother reside in the body and mind of adopted people (Dennis 2014, p.10).

Silence and secrecy within adoption can also impact on the interpersonal relationships of adult adoptees whereas openness helps in their resolution of adoption-related issues as mentioned in the introduction. Adoptees whose families are more open and honest tend to be closer to their adoptive parents and they often are seen to identify their parents as more caring and less controlling (Passmore et al 2006, p5).In the case of families where secrecy and silence prevail there can be evidence of social and family loneliness and avoidant attachment as previously mentioned.

Past practices in adoption saw original birth certificates replaced with an amended birth certificate containing the names of the adoptive parents (Passmore et al 2006, p1). Some adoptive parents were given a lot of information about the birth parents and were happy to share this with their child while others choose for different reasons to ignore the information given. In some cases no information was available about the birth parents at the time of adoption.

Following a re-union many adoptees go on to discover that they were given another name by their birthparent other than the one they are now known by. Thankfully in current adoption practices families are encouraged to honour the birth name of their child. According to Deborah Gray, social worker and author "it is disconcerting to have so many identity factors change, and also to have their names changed". Deborah works with parents and professionals in helping them in understanding the impact of a child's early trauma on their emotional development.

Cashin (2006, p221) an adoptee, believes that "too many adopted people have been made to feel abnormal or a bit crazy when they have been simply responding to feeling abandoned".

In working with adoptees, therapists should be aware and be able to recognize the "normative crises" (Pavao, 1998) experienced by their clients. Having an awareness of adoption loss and how it can affect development tasks is vital. Understanding how transitions, life events and anniversaries can trigger a renewed sense of loss for the client is necessary in providing adoption-sensitive counselling. Knowledge of what post-adoption supports are available to the client and a readiness to help them access these supports can be useful.

An understanding of the complex emotions surrounding search and reunion is also vital to us in supporting our clients.

The Adoptive Parents

As with birthparents being victims of the situation of untimely pregnancy and lack of support from a partner, family and society, so too are pre-adoptive couples victims of the situation of infertility and lack of support and secrecy that surrounds it. This can often result in a lifelong experience of pain, guilt, shame and loss (Pavao Maguire 2003). It is widely believed that a couple are not ready for adoption until they have had time to process the fact of their infertility and the emotional trauma surrounding it (Renne 1977). According to Rennee (1977), infertility is a life crisis and it is estimated that 60% to 70% of couples applying to adopt are still experiencing stages of grief such as shock, protest or despair. It is therefore important for adoption workers to help pre-adoptive couples bring their grief into awareness. In many cases this however does not happen and the unresolved grief around the infertility is carried through into their parenting role with their adopted child.

According to the Canadian Sociologist David Kirk, unrealistic or unmet expectations by adoptive parents lead to family instability (Brodzinsky et al 2005). Kirk says that adoptive parents are confronted with unique challenges not experienced by biological parents. They have to accept the reality that their children are not biologically connected to them and have the task of sharing this information with their children and supporting the child's reaction to it. They have to cope with the fact that their child will want to search for their origins. These challenges can be seen as "role handicaps". Parents utilize two coping patterns in managing stress associated with these role handicaps. They utilize either a rejection-of-difference (RD) attitude or an acknowledgment-of-difference (AD) attitude. Parents who adopt an RD attitude tend to minimize or deny the inherent differences in adoptive family life and try to simulate the biological family as much as possible and avoid discussions re origin. The AD attitude more readily accepts the child's dual connection to two families.

They have to accept the reality that their children are not biologically connected to them and have the task of sharing this information with their children and supporting the child's reaction to it.

The secrecy in an adoptive family and the denial that the adoptive family is different builds dysfunction into it. John Bradshaw, the well renowned therapist, says "A family is only as sick as its secrets". (Verrier 1993, p8),describes a situation where a 33 year old finds a paper that reveals he is adopted. He did not feel shocked by the fact itself but by the betrayal of the fact having been kept from him for all those years. Even though the betrayal did not fully manifest until adulthood, it had been an unconscious barrier between him and his parents throughout his childhood years and beyond. There was always a secret, always something that he was not being told. As previously mentioned, by parents keeping that knowledge unconscious, they deprive their child of a context in which to place the feelings caused by their preconscious experience of that loss. The child can then act out with behaviour that the adoptive parents find hard to cope with.

Adoptive parents must be mindful not to put the responsibility of integrating into the family on the child. The child has already made all of the adjustments he or she is capable of making. The adults who choose to adopt need to be the ones to adjust into the role of becoming parents (Dennis 2014, p68). According to Dennis adopting a child will not erase the loss of a stillborn or miscarried biological baby or the pain of infertility for the couple. Equally their presence in the child's life will not 'cure' their trauma nor will it mean its effects will vanish. The scars from their wounds must be acknowledged, accepted and treated with love, tenderness and patience.

Allowing feelings such as loss, frustration and inadequacy in a therapeutic space can be most beneficial in one's role of parenting.

The Birthparents

In the past, decisions about what happened to a child born out of wedlock belonged essentially to society. 'Attitudes were protective towards such a child and punitive towards the parents' (Watson 1986). These parents were seen to have broken two of society's most honoured taboos: they engaged in sex before marriage and then gave away their own flesh and blood. Society traditionally has felt a right to intervene and adoption was offered as a solution to an unplanned pregnancy (Watson 1986). According to Watson, areas in which adoption is likely to have long-lasting impact on the parent making the decision, usually the birthmother, are: decision making itself, separation and loss, family relationships, relationships with the opposite sex and self-image. In some cases the decision to place

a baby for adoption was made by a young girl, and in some cases this was her first major decision in life in which she had no experience, knowledge or support. In some cases parents made the decision for the girl and the adoption professionals assured her all would be well; she would forget the experience; go on with her life and have more children when the time was right. This however, was seldom the reality and the trauma of separation remained held within the mind and body.

The most obvious ramification for birthmothers is the unresolved sense of loss that they feel' (Watson 1986). Loss is a universal human experience and grief is the process that follows a significant loss. Mourning is used to facilitate the grief process. As denial is the basis of the traditional adoption model, the grief process is never allowed to begin and may only ever begin if and when a re-union occurs when the child is an adult. An anniversary of a child's birth, rather than serving as an opportunity to mourn the loss, often serves to aggravate the pain.

'The outcome of women who relinquish an infant has received virtually no attention in the psychological, psychiatric or obstetric literature, nor is it usually mentioned in the literature on adoption' (Condon 1986, p.117). According to Condon, the relinquishment experience differs from prenatal bereavement in four psychologically crucial aspects. Firstly most birthmothers feel that relinquishment is their only option due to the stigma of single motherhood; pressure from parents or professionals; and a general lack of support. Secondly, their child continues to exist and develop but remains inaccessible to them. The situation is sometimes compared to that of relatives of servicemen "missing, believed dead" in wartime. Disabling chronic grief reactions were particularly common after war in such relatives. Thirdly, lack of knowledge about the child permits development of a variety of disturbing fantasies in the birthmother, such as the child being ill, unhappy or dead or the fantasy of him hating his or her relinquishing mother. Fourthly, birthmothers see their efforts to acquire knowledge about their child as being hindered by an uncaring bureaucracy. Confidential files are kept out of reach, names changed on birth certificates, leading to the anger that is associated with the original event being kept alive and refocused onto those that seem to keep mother and child separated.

'Kaiser-Permanente Health Care conducted a study of birthmothers who relinquished babies and noted forty percent reported depression as the most common emotional disorder. Sixty percent reported medical, sexual and psychiatric problems' (Snodgrass 1998). According to research far too many birthmothers did not have another child. Ninety-six percent of birthmothers, when asked, said they would welcome the opportunity for a reunion with their child.

Adding to the silence that surrounds the adoption experience is the myth that suggests that a child born out of wedlock has only one natural parent. Little research is available on the experience of birthfathers and they have been very much the forgotten part of the adoption experience. Society has labelled them as individuals, for whom adoption of their child is supposedly trouble-free. However this has seldom proven to be the case and the trauma experienced by mothers can be attributed to fathers also. According to Clapton 2011, for most men adoption of their child cast a life long shadow and interfered with their subsequent relationships. Their subsequent parenthood was also a conflicted area.

It is important for mental health professionals to be aware that reunion between adoptees and birthparents bring forth feelings that were buried at the time of relinquishment for all parties of the triad.

Reunion

It is important for mental health professionals to be aware that reunion between adoptees and birthparents bring forth feelings that were buried at the time of relinquishment for all parties of the triad. The adoptee gets a glimpse of somebody that looks like them and acts like them and they start to realize the lost part of themselves. Reunion can also undermine the security of the adoptive parents. Many of the feelings that come forth hark back to the time they started to adopt. Though the infertility issue has been denied and repressed from consciousness it is still an unresolved loss and may be revived at time of reunion. In addition to reviving the loss of biological parenthood, reunion actualizes a lifelong fear for the adoptive parents that the birthparents will take back the child (Gediman & Brown 2000, p.228). Birthparents that went on to marry often never spoke of the relinquishment again till a reunion happened. This often created an unhealthy bond based on deception and couples would benefit from exploring this post reunion. For

The adoption community needs to be listened to and heard by society and most importantly by the mental health professionals committing to working with them.

birthparents reunion catapults them into experiencing "the lost piece" the unresolved grief and mourning from the past-at the same time bringing great joy (Gediman & Brown 2000, p65). Emotional confusion is quite common and some may feel themselves going from "the heights of joy" to the "depths of despair" with frightening frequency. Unresolved issues can often get in the way of the relationship with their child who is now an adult.

A huge amount of emotional energy can be spent reviewing the past and the question of "what if?" arises. Being able to acknowledge the past, and deal with it constructively, is a critical post-reunion task for those that have not done so.

Conclusion

"And the truth shall set you free", has a greater meaning for all those affected by adoption (Dennis 2014, p.25). Honest discussion around adoption and the implications for those involved and the professionals working with them, however painful, is far better than simplistic and uneducated views that trivialize or ignore the truth. A sizable amount of our community are affected by the lifelong issues that adoption presents us with. If these core issues are properly acknowledged and addressed outcomes for our clients can be very good as can the benefits to them living well within their families. The adoption community needs to be listened to and heard by society and most importantly by the mental health professionals committing to working with them. We have a duty to our clients to educate ourselves on the specific issues connected to adoption.

"In therapy one can learn how to open one's heart and feel whatever it has to feel and only then is it possible to figure out how to become whole again without the doubts or the fear that has been holding the person back (Cashin 2006, p.184).

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Patricia Losty

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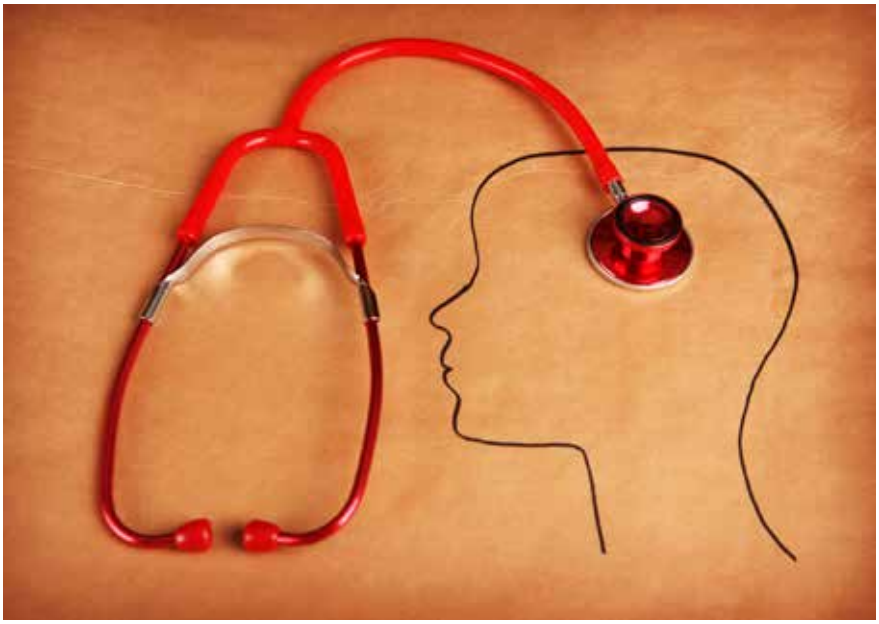
Practitioner Perspective

A Conversation on DSM-5 and its Usefulness in Counselling and Psychotherapy

By Eugene McHugh



While attending the American Counselling Association's Conference in March 2017, among other workshops on cyber security and ethics, I enrolled for presentations on using the DSM-5 (Diagnostic and Statistical Manual Of Mental Disorders 5th Edition) and its instruments of assessment that counsellors can use for clients.

My curiosity was raised by the various views and objections that therapists have around using DSM and ICD 10 including my own. From a personal perspective, I am fully behind the idea of not labelling our clients and in meeting them wherever they are. However, I am curious as to how we might use the assessment tools to inform ourselves about our clients' lives and in turn support interventions to aid their emotional growth.

It is my view that our therapeutic work centres around emotional health rather than mental health and I consider that emotional health results in good mental health. Indeed, one could argue that bad emotional health leads to mental health issues and many of the classifications in DSM.

What would be the pros and cons of embracing a tool that is internationally used and recognised by the medical profession and the insurance industry?

Many therapists already use assessment tools in their practice (eg. Clinical Outcome in Routine Evaluation (CORE)) and find this useful as a research tool and for tracking a client's progress over their time in therapy. To be clear, I come from a humanistic and integrative background before I pose the following question.

What is the resistance of our profession to using the DSM-5 or the World Health Organisation's ICD10 (International Classification of Mental And Behavioural Disorders, 10th Revision) as a useful resource? Further, what would be the pros and cons of embracing a tool that is internationally used and recognised by the medical profession and the insurance industry?

A Brief History of the DSM

The DSM is on its fifth revision now. Its inception in 1952 by the Surgeon General was in response to armed forces returning from World War II. It was originally called "Medical 203" and due to the involvement of the American Psychological Association (APA) was renamed as DSM. The original DSM listed 106 conditions over 103 pages. The second edition appeared in 1968 and was

increased to 184 conditions over 134 pages. Due to various issues around language and certain conditions it went through six reprints with the last appearing in 1974. There was an attempt to bring the DSM into line with the ICD which was published in 1942, listing mental disorders for the first time. The third edition was published in 1980 with 265 conditions over 494 pages.

In 1987 a revised edition called DSM IIIR was published with 292 conditions over 567 pages. As with previous editions there was problems with some of the diagnoses contained such as homosexuality and pre-menstrual diagnosis and these conditions were removed. There was also an effort to make the manual more descriptive in tone. DSM IV was published in 1994 listing 297 conditions over 886 pages and the main change was to look at the importance of distress or impairment in social or occupational dysfunction in areas of a persons' life. A revised text edition was published in 2000 called DSM IV TR and it separated the various conditions into classifications such as "clinical", "personality", "intellectual", "medical", "psychosocial" and "environmental". This brings us to 2012 when DSM-5 was approved and then published in 2013.

The Current Version

The work for DSM-5 started in 1999 and took fourteen years to come to fruition and was not without problems. Its purpose was to "increase clinical utility while maintaining continuity with previous editions" (Dailey, F. D., Carman, S. G., Shannon, L. K., & Barrio Minton, C. A. 2014. P.3). The initial task of revision was given to seven workgroups looking at nomenclature, neuroscience and genetics, developmental, personality, mental disorder, cross cultural, and disability. This was later extended in 2007 to thirteen working groups and resulted in thirteen conferences between 2004 and 2008. There were three public consultations between 2010 and 2012 and 13,000 professionals were involved in commenting on the proposed criteria. The first trials held in 2010 involved 279 clinicians (APA, 2012b, 2012c), and the second trial involved small group practices including licensed counsellors in private practice. The American Counselling Association (ACA) played an important part as an advocate for the counselling profession during the drafting of the manual. The ACA had five areas of concern on behalf of counsellors,

1. Applicability across mental health professions
2. Gender and culture
3. Organisation of the multi-axial system
4. The lowering of diagnostic thresholds and the combination of diagnosis
5. The use of dimensional assessments

ACA expressed their concern about the validity and credibility of the manual and submitted a prioritised list of issues. Sections of the APA also expressed their concerns. The result was major structural and philosophical changes in how DSM-5 was presented. It included ICD-9-CM (Clinical Modification) and ICD-10-CM codes to cater for billing in the USA at the mandate of the US Department of Health.

Counsellors can add in other subjective information to the codes, but it is anticipated that there could be difficulties that may arise in the understanding and interpretation within multi-disciplinary teams.

Multi-axial versus Non-axial

The most significant change to the manual was the removal of the multi-axial system. Dailey, et al state:

> Dropping the multi-axial system confirms what counsellors from a wellness perspective have been claiming for decades – that differentiation among emotional, behavioural, physiological, psychosocial and contextual factors is misleading and conveys a message that mental illness is unrelated to physical, biological and medical problems (2014, P.13).

They suggest that assessments need to be more holistic so that diagnosis is not just a simple listing of codes. Counsellors can add in other subjective information to the codes, but it is anticipated that there could be difficulties that may arise in the understanding and interpretation within multi-disciplinary teams. How the chapters were organised has also changed with DSM-5. The listing is now based on a developmental or lifespan approach. Dailey et al, suggest that, the change of listing from 'specified disorder' to 'unspecified disorder' allows the clinician not to specify a particular disorder which supports the dimensional aspect of the client. They state that "this

change reflects the philosophical assumption that mental health disorders are medical conditions" (2014, P.15).

Personal Viewpoint

I would argue coming from a body perspective, that there is a differentiation between Emotional Health and Mental Health where the former is a 'dis-ease' and the latter is a physical 'disease' within the client. The latter may be caused by long-term emotional issues impacted by the stress response within the autonomic nervous system and / or genetic issues.

Centrally, I believe in the clients' ability to self-heal and to resolve emotional issues using their own resources with the support of a good therapeutic relationship. I do not believe it is good to provide a label for the client on which to hang their coat and which may prevent them from forming that self- belief in their own strengths. I do wish however to look at using the DSM as an assessment tool for ourselves and as a communication tool with other professionals such as:

- Medical practitioners
- Insurance companies
- Employee Assistance Providers (EAP)
- Psychiatric services
- Researchers

In private practice, therapists may find that insurance companies or agencies require DSM criteria to process payments for services provided. I am putting forward the proposal that as a profession, it is in our best interest to become proficient in the use of the DSM manual when we are in contact with other professions (such as the above) when discussing the treatment of our clients, should it be necessary. To be abundantly clear, I am not proposing that DSM criteria are discussed with clients, it is about being more proficient in the use of an internationally recognised tool when in discussion with other professionals and agencies. It is my belief that it is essential that the therapist is trained to consider themselves competent in the use of the manual.

Assessment is an important part of a client intake and forms the hypothesis for client focus, goals, and possible duration. In private practice, this may be an informal or formal process and ethically is a necessary part of the intake as it may involve a therapist having to consider a referral to another professional better placed to support the client

Issues for Counsellors

I can understand how this labelling can present a problem for anybody coming from a person centred or humanistic and integrative perspective. One takes the client "as they are wherever they are" and using theoretical maps, one makes a hypothesis to assist and support the client in the challenge that they undertake in resolving their presenting issues. I consider that once the client walks through my door or makes an initial phonecall, I am making an assessment as a human being. One observes and judges their gait, dress, appearance, culture, shape, facial expressions, mannerisms and tone of voice. Palmer & Dryden (1995, P. 19) suggest that there are certain questions that the therapist should keep in mind while doing an assessment, some of these are listed below:

- Are there signs of psychosis?
- Are there signs of organicity, organic pathology, or any disturbed motor functions?
- Is there evidence of depression, or suicidal / homicidal tendencies?
- What appear to be important antecedent factors?
- Are there clear indications or contra-indications for the adoption of a particular therapeutic style?

One can see that these might not be considered as person centred questions and more from the medical model. They form, however, an important part of our hypothesis and decision making process for the client. In addition, the reality for many counsellors that may be engaged with national (eg. National Counselling Service (NCS) and Counselling In Primary Care (IPC)) and private agencies (eg. EAP providers) is that clinical assessment is a critical part of the work whether using Beck's Depression Scale or CORE OM. Corey (1996) states "the purpose of diagnosis in counselling and psychotherapy is to identify disruptions in a client's present behaviour and lifestyle". He goes on: "a diagnosis is not a final category; rather, it provides a working hypothesis that guides the practitioner …" (p. 68). Therefore, assessment is an important part of a client intake and forms the hypothesis for client focus, goals, and possible duration. In private practice, this may be an informal or formal process and ethically is a necessary part of the intake as it may involve a therapist

having to consider a referral to another professional better placed to support the client. One could certainly argue that as a therapist I am already making a diagnosis, albeit for my own use, in establishing a working hypothesis for the benefit of the client. Reeves writes, "… as counsellors, we can acknowledge these early assessments and 'bracket' them in such a way that they can inform our thinking, but not direct it" (2008, p63).

Assessment questions need not be a long list of strict queries, but can be integrated at an early stage to start to understand what is going on for the client. Reeves proposes:

> That these impersonal questions can be quickly transformed into a flowing and respectful dialogue, that not only provides the counsellor and the client with a clear overview of difficulties and problems, but can help the client to feel listened to and taken seriously" (2008, p.66).

It may be understanding the medication that the client is on and how it impacts on their daily lives. It may be understanding their experience a psychological service which they attend. I wonder how many therapists have a copy of MIMs in their office to understand the effects of certain medications on their clients as these can impact on the therapeutic process and the relationship. Corey (1996, p.69) quotes Brammer, Shostrom, & Abrego, (1989) as proposing that therapists, "simultaneously understand diagnostically and therapeutically"(P.148).

I accept that while all the afore-mentioned can be argued as not being person-centred, professionally it is something that one does for the benefit of the client. As Reeves suggests, it does not direct how it is brought to the client, but the therapist does use it to understand the clients experience. This will help the therapist in accompanying the client in their self-discovery, which can be argued is a person centred effort.

I see the need for the counselling profession to take on a responsibility to understand other professions so that we can engage with their language for them to understand our language.

Relationship Model versus Medical Model

As stated more than once, I absolutely agree that it is the supporting and honest therapeutic relationship that is at the core of the work that our profession provides. However, as a therapist I have four years of both objective and subjective training and practice in how to accomplish this non-judgemental, non-aggressive and supportive work for the client. A student spends the first two years, in most cases, building this capability to sit with a client. It is the training in practical skills and techniques, and the depth of personal reflection that equips professionals to sit with a client no matter where they are. That is the difference between the counselling profession and any other profession in the mental health field.

This practical competence sets the counsellor apart to deliver the service he or she provides. This is, for me, the place where other professions divide from the psychotherapeutic relationship place and where I see the need for the counselling profession to take on a responsibility to understand other professions so that we can engage with their language for them to understand our language. Corey (1996) quotes Goldfried and Castonguay (1992) as they predict the future directions for therapy: "it would not surprise us if we saw future generations of therapists choosing to be trained in one particular orientation, while at the same time showing a greater openness toward the theoretical, clinical and empirical approaches" (P.5).

So, should professional counsellors embrace a medical approach in order to aid our work? While discussing mental disorder and a lack of empathy in primary carers and the later pathological developments, Ute Binder in Thorne and Lambers (2006) proposes that, "A knowledge of pathogenic factors makes it possible to activate constructive, healing developmental processes through a specific therapeutic empathic understanding of the disorder" (p.216).

Let's look at a common condition that probably counts for a large percentage as a presenting condition: "general anxiety disorder". DSM-5 tells us that excessive worry or anxiety about a number of events is a key feature of the issue over most days within a 6-month window. It suggests that clients are keyed up or fatigued with muscle tension and sleep disturbance etc. It advises the therapist to consider cultural factors and whether there are issues around PTSD, bipolar, and psychotic disorders. It gives a list of questions that may clarify the issue and other factors that may impact on the client (Dailey et al, 2014. p. 81-85). This useful information may give a good understanding of what

is going on for the client and may provide guidance in what questions may be offered in the assessment. In the DSM-5 manual itself anxiety is covered from p.189-233, thus providing a useful reference for what might be present.

Another example is "substance related and addictive disorders" which gives a definition for addiction and suggests the criteria we might consider while doing the assessment. It also offers various types of substance misuse for consideration (Dailey, et al., p.149-164). Again, in DSM-5, addictive related disorders guidance and information is provided from p.481-590 providing valuable insight into a client's world. These examples from the DSM are offered as they are common in most practices. The manual gives the therapist the ability to inform themselves in making a useful hypothesis so that the client can be supported in the healing process.

Conclusion

As discussed initially the information is for the therapist's benefit, which in turn supports the client. In embracing this tool in dealing with other professionals, it facilitates a clear and common language, especially where as a professional one is looking for recognition from insurance companies and national health providers. The result may be a more integrated multi-disciplinary approach for the client. This is to the benefit of the individual that presents looking for professional support to deal with an issue which is causing them distress. It is my view that, as professionals, it is incumbent on us to inform ourselves on best practice. The use of a tool such as DSM-5 supports our profession in this regard and facilitates a better engagement with the mental health industry. Finally, it is useful to consider that in the USA and in Australia, all counsellors are trained in the use of DSM. Philip Armstrong CEO of the Australian Counselling Association believes that it is an important part of their conversation when they obtained recognition as professionals by the Australian authorities. On balance, I believe that with careful use, DSM-5 is a worthwhile tool in Counselling and Psychotherapy.

The result may be a more integrated multi-disciplinary approach for the client.

Glossary of Terms

Becks Depression Scale – Created by Arron T Beck, 21 Questions with Score of 0 to 3.

CORE – Clinical Outcome Routine Evaluation, 34 Questions scored in 4 categories

DSM – Diagnostic Statistical Manual

EAP Schemes – Employee Assistance Programmes

ICD – International Classification of Disorders

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Eugene McHugh

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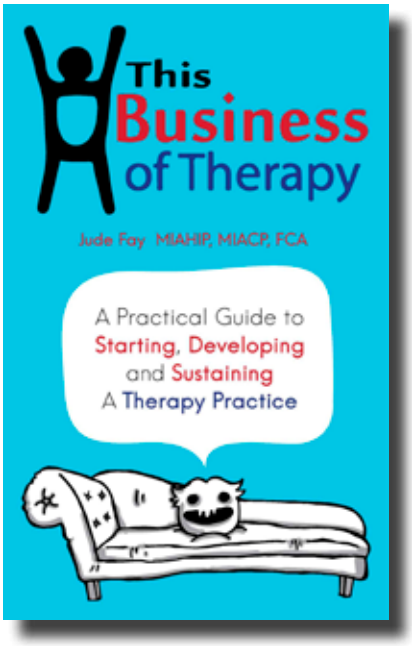
Book Review

Title:	*This Business of Therapy: A Practical Guide to Starting, Developing and Sustaining a Therapy Practice*
Author:	*Jude Fay*
Published:	*2016*
ISBN:	*978-1540710451*
ASIN:	B01MXECMJE
Reviewed by:	*Cóilín Ó Braonáin PhD, MIACP C. Psychol. PsSI*

Psychotherapy is sometimes seen as a vocation, or a labour of love, which no doubt it is. However, a growing number of therapists are entering counselling and psychotherapy, with a view to also establishing a financially viable practice. If you wish to make a comfortable living from psychotherapy, 'The Business of Therapy' is just the book for you. Jude Fay, the author, is both a psychotherapist and a qualified accountant, so she can speak of both the 'work' and the 'business' with considerable authority.



The book is structured around the Six Pillars of running a successful therapy practice; the 1st Pillar being - Owning Your Practice. While counsellors are always very committed to their clients, there can be some ambivalence regarding self-promotion, charging a realistic fee and avoiding excessive pro bono work. Fay mentions that planning is also essential: For example, many therapists find that the months of January and August can be very quiet, so forward planning is necessary to cover the monetary dry spells. Persistence is also necessary because it takes times to get known and to build a solid client base. Furthermore, uncertainty will be a constant companion, for example, as we recently experienced, a couple of weeks with the Aussie flu can create a large hole in the bank account.

The 2nd Pillar is Knowing Your Practice. Is the population in your area sufficient to support a practice? It may be worth-while commuting to a large urban centre which has both numbers and anonymity. However, office space can be expensive. Then again, therapists can share a space to minimize costs. On the other hand, working from home will keep costs down in terms of rent and travel expenses. But will clients come if they can be easily seen or have their car recognised by neighbours? A business name can help, but it may need to be registered with the Companies Registration Office. It can also be advisable to register your business name as a trademark with the Patents Office, so that it cannot be misappropriated by someone else after you have spent years promoting your brand.

Pillar #3 concerns Growing Your Practice. Most clients self-refer, so they will come if they know you exist. The best way to make yourself known is through a website, ideally in conjunction with using Google Ads at first. Small ads in local newspapers can help and while referrals from GPs would be great, don't count on that unless you are personally known to them. Should you specialise in a niche area of therapy? Only if the population that you draw from is quite large; a small pool does not hold many fish. And of course, from an ethical perspective we avoid making any unsubstantiated claims about our therapies, rather we advertise our existence, where we are and what we do.

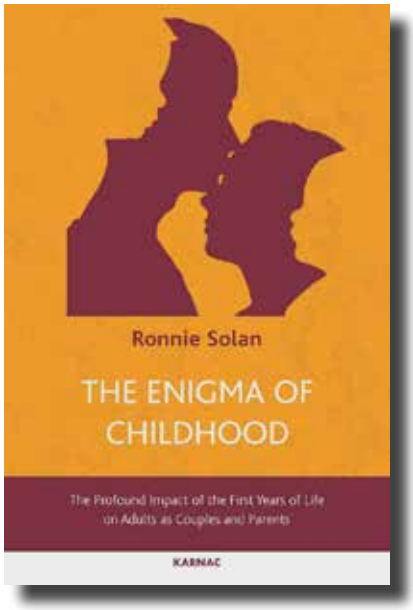
The 4th Pillar – Managing Your Practice looks at the practicalities of keeping records, data protection, professional accreditation, professional indemnity and public liability insurance, book keeping and tax returns. This chapter also contains useful information on the implications of working in partnership. The 5th Pillar – Minding Your Practice looks at the roles of supervision, accreditation and CPD. Pension contributions are considered as is self-care and the work/life balance. Finally, we arrive at the 6th Pillar - Valuing Your Practice. The effort to make enough money to make a practice viable is considered, including the costs of running a practice and the necessity to charge a realistic fee.

Jude Fay writes in a very clear straightforward style, with many of the above aspects of business laid out in lists and bullet points. The font size of the print is unusually large, but that seems to add to the clarity and accessibility of the book. Also, this is an Irish book by an Irish author, so it contains no irrelevant British or American-specific information. I strongly recommend this book to new therapists who need guidance on the business of therapy and who wish to avoid the pitfalls of figuring it out as you go along.

Book Review

Title:	*The Enigma of Childhood: The profound impact of the first years of life on adults as couples and parents*
Author:	*Dr. Ronnie Solan*
Published:	*2015*
ISBN:	*978-1-78220-211-0*
Reviewed by:	*Alan Kavanagh*

> Wisdom is achieved largely through man's ability to overcome his unmodified narcissism and it rests in his acceptance of the limitations of his physical, intellectual, and emotional powers – *Kohut (1966) as cited by Solan (2015, p.49)*



Before I turned a page of this book, I was captivated by the cover's imagery. I was impelled to reflect inquisitively on my inner child. The author highlights 'the profound impact of the first years of life on adults as couples and parents'. Do we seek our parents in relationships or rebel in the opposite direction? Are the promises we made, vowing that "I will never do or say that when I have children or a partner", ultimately broken in moments of elevated emotion? In the aftermath, are we left in a state of confusion, wondering why we act in ways that are at odds with the values we swore to uphold?

It is generally believed that attachment is a primal need and also that the unconscious has an undeniable and immeasurable influence on our lives. Additionally, the author proposes the question 'do opposites attract or is it that like attracts like?'

Value can be gained from the author, Dr. Ronnie Solan's insight and life-long dedication to understanding what we do not fully know, even for those of us not inclined to a psychoanalytic mindset. She articulately argues that the crucial early development of a child, from birth up to three years, reverberates throughout our adult lives.

Dr. Solan's book "focuses on four main themes: narcissism, the ego, object-relations, and separation-individuation." However, it is her major contribution of conceptualising the functioning of healthy narcissism 'as an [innate] emotional immune system for safeguarding the familiar sense of self', that dispelled my previous perception of narcissism as being exclusively pathological.

Moreover, the elaboration on the term object-relations to 'jointness-separateness' was interesting. It is an enriching text and I will revert to this book time and again as I continue on my own journey toward a greater understanding and awareness of personality. At times I had to refer to the comprehensive glossary to fully understand the psychoanalysis terminology, however I believe this book is capable of wide readership within the counselling profession. This text has created a desire in me to delve deeper into psychoanalysis. While there is an upsurge in the popularised positive psychology, I question, if cost-effective quick-fix solutions to deep-rooted issues really resolve the fear-filled problems of today? I suppose it must be acknowledged that no theory has all the answers.

Anecdotally we hear that psychoanalysis is a cold, expensive therapy. In contrast, by reading Freud's work and that of respected others which are littered throughout this book, one realises that this is not the case. By getting to know the warm-hearted author, Dr Solan, any such beliefs about psychoanalysis are changed.

I attended a lecture by Dr Eve Watson on psychoanalysis and I naively asked 'how can an analyst create a relationship that facilitates the space for a client to heal themselves, if the psychoanalyst is only listening?' Her response is relevant to this book, as she stated that "most people listen to reply and do not listen to understand". If so, are we more able to hear, in the fleeting moments the unconscious speaks? This book shows case examples to illustrate Dr. Solan's work with infants, children and adults.

Is it really as simple as inputting positive thoughts to negate the negativity? Do we listen to our inner child with compassion, like we would if our children needed to be heard? Does the inner-child come out to play in our intimate relationships? This book has aroused a plethora of questions in me but also in turn answered some too. In summation, it is quite a task to re-connect with the inner-child. Listen, we are all human, but why is it that we fear the unknown so much, regardless of how destructive the familiar can be?