Prism of Meaning

Guide to the Fundamental Principles

of

Viktor E. Frankl's Logotherapy

by

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Contents:

Introduction:

The Institutes of Logotherapy arose from the works of Prof. Dr. Frankl. In 1946, he published a book, From *Death Camp to Existentialism*, which later became known as *Man's Search for Meaning*. In the early sixties, Dr. Elisabeth Lukas, and Dr. Joseph Fabry were two of his students who read these works, and attended Frankl's seminars at the Poliklinic Hospital in Vienna. Out of this grew the first Logotherapy Clinic in the USA in 1970, the Institute of Logotherapy in Berkeley, in 1977, and the German Institute of Logotherapy, in 1982, under the guidance of Dr. Heines, a colleague of Prof. Frankl. Since 1986, Dr. Lukas was leading the South German Institute of Logotherapy. Dr. Frankl's other students took his teachings and applied them in their own countries.

Frankl never imagined that, over the years, there will be so many institutes devoted to the study of logotherapy. He in fact wrote an article called the "*De-gurufication of Logotherapy*," in which he definitely spoke about the need to look beyond the beliefs of one single founder, and to test the theories of logotherapy in everyday life. He always believed that logotherapy should be used in conjunction with other therapies and not as a therapeutic modality on its own.

After the first Institute of Logotherapy was established, there were many institutes to follow, and to date, there are institutes on each continent. There are regular International Conferences in different languages, including, German, English and Spanish.

Very aptly, in the preface to the *Man's Search for Meaning* (1984), Gordon Allport referred to logotherapy as "*…the most significant psychological movement of our day*." In the same preface (1984) The American Journal of psychiatry calls Frankl's work *"...perhaps the most significant thinking since Freud and Adler*."

As we see how logotherapy spread, it is interesting to reflect on the fact that a detailed outline of its basic tenets and principles is missing from university curricula, although this situation is changing gradually. For example, Dr. Kent Estes' article, *Logotherapy in Counselor Education: Important but Neglected (1997)* refers to the findings of a national survey of 525 university programs by Kelly (1994), which concluded that although questions of meaning and purpose in life are at the core of many concerns presented to counsellors, this dimension is lacking from the preparation of counselling professionals. Similar preparation is lacking from most training programmes of the schools of psychology, psychotherapy, or medicine.

An article that appeared in the American Journal of Psychiatry (2000), written, among the others, by Frankl's niece, Liesl Kosma, provides a brief, concise, and realistic summary of logotherapy's main tenets. The authors remark that logotherapy "*remains a neglected but most worthy legacy*."

In the light of these reflections, the purpose of this book is to present the core principles of logotherapy, and to outline how logotherapy can be used in conjunction with other forms of interventions.

As we proceed, we will illustrate how logotherapy is more than a philosophy, but it also a **theory of personality**, and **therapy**.

Our first consideration in this regard will rest on the assumption that each theory leads to certain practical applications in psychology, and the practical applications refer back to an underlying school of thought.

Thus, we will examine the theory behind logotherapy, as well as its concrete applications in clinical practice.

Our goal will be to illustrate the inductive and deductive interplay between theory and therapy, and to do this in the context of discerning meaning; enriching both theory and practice.

With this aim in mind, the book's structure will follow a carefully prepared format:

Volume I will be devoted entirely to Logotheory. **Volume II** will contain the chapters which portray the practical applications of logotherapy. Each chapter will end with **Points to Ponder**, which aim to bridge the individual chapters, and to highlight connections between theory and practice. Corresponding to each chapter, the **References** section will provide an extensive list of the relevant sources, and related bibliography.

The writing of this book rests on much preparation: In essence, it follows the ground-structure of my *Doctoral Dissertation* (1999), entitled "*The Applications of Viktor E. Frankl's Logotherapy in Counselling Psychology*," which contains a comprehensive overview of the fundamental elements of the philosophy and practice of logotherapy, based on an extensive review of the literature, both in the German and English languages. The *Dissertation* was based on my formal studies in psychology, counselling psychology, and in logotherapy, whereby I had the opportunity to study with leading logotherapists, such as with Dr. Robert C. Barnes, President of the International Board of Directors of the Viktor Frankl Institute of Logotherapy, and with Dr. Elisabeth Lukas, Director of the South German Institute of Logotherapy.

Since the finishing of the *Dissertation*, there were other opportunities to familiarize myself with the area: I had the privilege to engage in further studies with Dr. Lukas in Furstenfeldbruck, Germany, and to complete my Diplomate Clinician in Logotherapy credential. During this time, I was able to continue to apply logotherapeutic principles in my clinical practice, and to offer seminars on the topic. Also, I methodically supplemented my original references with further resources. These, along with my life experiences, contributed to my growing understanding of Logotherapy, which I tried to incorporate into the present book.

"*Prism of Meaning*" reflects my desire to capture the foundations of Logotherapy, and to offer it not only in the form of a source book, but as a guide to students, professionals, interested lay people, and to those seeking advice. Thus, my hope is to share Logotherapy's wisdom with a wide audience.

I trust that it may be a valuable book, allowing access to the treasures of the wisdom of Logotherapy, for all those who seek it.

VOLUME I--LOGOTHEORY

Chapter I: The Roots of Logophilosophy in the Life of Dr. Frankl

Anyone who is familiar with the book "*The Discovery of the Unconscious*", a classic book, written by Henri F. Ellenberger (1970), which details the "*History and Evolution of Dynamic Psychiatry*," will appreciate the detailed biographical accounts through which the author leads the reader to understand the social, historical, philosophical, and teleological reasons why for example, Sigmund Freud, or Alfred Adler, came to certain conclusions, deducted specific ideas, and put forth their convictions.

Interestingly, the book starts with a historical and anthropological account of primitive healing practices, and gradually, it leads us up to the turn of the Century Europe, and Vienna.

The book aims to end with the work of Carl Jung, and the subsequent "*dawn and rising of the new dynamic psychiatries*," leading up to our current times. In its foreword, the author expresses gratitude to significant contributors.

Among the contributors, we encounter the name of Professor Viktor Frankl.

Like Sigmund Freud (1856-1939), and Alfred Adler (1870-1937), Frankl (1905-1997) grew up in a middle class Viennese environment. On a time scale, we can visualize how his life would have been influenced by the very same events, which were so well known to Freud and Adler. In fact, Sigmund Freud lived in a district not far from where Frankl was born, and, between 1899 and 1909, Alfred Adler practiced just opposite to the Frankls, at Czeringasse No. 7.

It is not too difficult to imagine how Frankl's life was shaped by the social events of his time, although in a unique way.

It is also not surprising for us to realise that Frankl was thoroughly familiar with the works of Freud and Adler, these great psycho-therapists.

However, throughout the years of studying the works, and collaboration with Freud, and Adler, Frankl came to develop his own theories, which he "*built on the shoulder of [the two] giants*" (Frankl, 2000; p. 52). This theory became known as the *Third Viennese School of Psychotherapy*, or Logotherapy.

Thus, while in our understanding of Frankl's life, and beliefs, we could to start with Ellenberger's seminal book, we would need to complement it with a narrative of Frankl's own experiences, many of which are found in his book "*Recollections*", published in 2000.

Another resource for understanding Frankl's life is the book *Man's Search for Meaning*. This is Frankl's most popular book, which has been translated into 24 languages, and sold more than 10 million copies world-wide (1997). The book details Frankl's experiences in the concentration camps:

As a Jew, and psychiatrist, Frankl spent three years in four camps in total. The names of the camps were Theresienstadt, Auschwitz, Kaufering III, and Tuerkheim. In *Man's Search for Meaning*, Frankl details not only the experiences, but also the circumstance out of which his basic philosophy arose with ever stronger conviction--that life has meaning under all circumstances.

The idea about life's meaning was not new to Frankl. Even as a young school boy, he was very keen on questions relating to life and death. When he was five years old, he wanted to become a doctor, and he dreamed of developing a life-saving medicine. As an adolescent, he had avid doubt about the ultimate meaning of life, and if such meaning exists.

Little did he know that he was on the path to discover a medication, or an antidote to a problem, with which generations of humanity had to grapple. This antidote was related to the question of suffering, and to the questions that suffering poses in human life. From his young adult years, Frankl was tackling the question of meaning in life, and purpose.

As a young medical student of neurology and psychiatry, he developed programs to help to reduce the number of suicides in the pre-war Austria. Then, later on, during the war, he stayed in Vienna to be close to and to save his parents. He entered the camps, but offered his skills in the service of his comrades. His book, *Man's Search for Meaning* was the summary of those beliefs that kept him alive, that touched so many people's lives. After the war he returned to, and continued to work in Vienna.

He became the Head of Neurology at the Poliklinik Hospital in Vienna, and Professor of Psychiatry and Neurology at the University of Vienna. He received many invitations to speak in Austria, and abroad, as well as received numerous awards, and honorary doctorates: [Frankl published over 700 articles, and wrote a total of 31 books, which were translated to 24 languages. He taught at over 200 universities, in more than 40 countries on all continents. He received numerous prestigious awards, and 29 honorary doctorates from universities around the world (Levinson, 2001)].

Dr. Frankl passed away on September 2nd, 1997, at the age of 92. He left behind a legacy of books, lectures, scientific articles, and presentations, and Viktor Frankl Institutes, where his students, in various fields of practice, continue to explore and to teach his approach to psychology and psychiatry.

The 1997 *Newsletter* of the Viktor Frankl Institute, written by Dr. Robert C. Barnes, captures Frankl's legacy as that of "…the last of the great European philosophers and psychiatrists of the Twentieth Century."

Further reviews of his vitae can be found in the following sources: The chapter entitled "Viktor Frankl's Life," in the Doctoral Dissertation by Ungar (1997), entitled *The Applications of Viktor E. Frankl's Meaning-oriented Approach to Counselling Psychology*, which provides a detailed review of Frank's memoirs with respect to the development of Logotherapy. [This article rests on Frankl's book "*What is not in My Books*" (1995), published in the German Language, and the same book published in 2000, in English under the title *Recollections.*

The article of Dr. Jay Levinson (2001) *Dr. Frankl's Vita, Achievement, Dedication, Humility,* appeared in the *International Forum for Logotherapy*. Dr. Levinson is a Clinical Psychologist, and he was a psychologist assistant of Dr. Frankl in Vienna.

From numerous interviews with Viktor Frankl, the Institute of Logotherapy carries one by Adolf Opel (1992). It is a thirty-minute-long tape, and gives a first-hand insight into the everyday life and the work of Prof. Frankl in his home in Vienna.

POINTS TO PONDER:

The following questions are included to ponder in relation to this Chapter:

* Have you visited Vienna, or seen travel-documentaries about the city?
* In your imagination, could you place yourself into the Turn of the Century Vienna?
* What do you think caused the most amount of suffering to the Viennese people during the Second World War?
* In what ways do you think people suffer in our days?
* What impresses you most about Frankl's life experiences?

Chapter II: The Three Pillars of Logotherapy

To date, there are several hundreds of different methods and approaches to psychotherapy. What differentiates these systems is their starting point, and their basic assumptions, which influences the standpoint they take towards the treatment of mental or physical complaints.

While it is not our intention to compare different treatment modalities at this point, it will suffice to say that all major schools of thought have **philosophical-**, **anthropological-**, and **clinical** roots. Form their characteristic vantage points they start with an evaluation of the whole of life, and human existence, which, in turn, reflects in how they approach aspects of reality.

This chapter is intended to present the fundamental assumptions of **Logotherapy**, a **meaning-oriented** approach to psychotherapy. Meaning-orientation makes Logotherapy characteristically different from other treatment modalities, in that it starts with the **essence of life**, and it is concerned with the **whole** and **purpose of life**.

According to Frankl (1967; p. 18), and Lukas (1998, p. 7), Logotherapy rests on three basic pillars, or three fundamental assumptions. These are:

(1) **Meaning of Life**;
(2) **Freedom of Will**; and
(3) **Will to Meaning**.

Corresponding to each of these fundamental principles are particular **(1) philosophical**; **(2) anthropological**; and **(3) psychotherapeutic** concepts which are embedded within Logotherapy.

(1) Meaning of Life—Logotherapy as Philosophy:

The Philosophy of *Meaning of Life* starts with the basic conviction that *"...life has unconditional meaning, which can not vanish under any circumstance"* (Lukas, 1989, p. 6). In other words, that life holds a meaning in any situation, even the most miserable.

This belief asserts that *the whole of the world has meaning and purpose to it, and therefore, every particle, every life, and every life experience potentially hide meaning in themselves.*

Meaning may not be always available to our human perception, and to our comprehension, for the reason that we are finite human beings. However, exactly this *finiteness* presents a challenge to us, which can only be overcome only with an unconditional expectation of meaning in life.

A uniquely human capacity that we all have, and which is similar to a pre-knowledge, or awareness of meaning in our lives, is called **intuition**. Our intuition is a **fore-knowledge**, that our existence is basically wanted in the word.

Reflecting on the mere fact of our existence, the miracle of life, the complexity, and beauty of nature, and the vastness of the universe, can make us aware that we have been protected, and that we are awaited in the world:

> "…The intuitions and sensing of all peoples and generations, concealed in a thousand symbols and rites, [implies] that the whole must have some kind of "ultimate meaning behind it", which goes beyond chaos and chance…." (Lukas, 1995; p. 2).

Even though, in every-day life, **suffering**, in the form of **pain**, **guilt**, and **death**, fate, and accidents, or simply being human, and aspiring for an understanding of life, and our place in it, presents us with a dilemma:

> "…The question is: Is existence nothing but a mass of nonsense, or it is a mass of ultimate meaning?" This question can not be answered by the natural sciences alone. It can not be answered at all, it is completely unsolvable problem—rather, it must be decided. All being is ambiguous: both interpretations—both the interpretations "nonsense and the interpretation "ultimate meaning"—are possible. Both are thinkable: that being is a total nonsense, and that it is a total ultimate meaning; but these are indeed two "thinkables", two thought possibilities, and not thought necessities. With respect to the decision we are called upon to make there is no logical coercion; in no way are we logically forced, logically obliged to decide for one or the other. Both interpretations are logically of equal status. Logically there is as much which speaks for the one interpretation as for the other. The equal status of the two answers: the answer "absolute nonsense" and the answer "absolute ultimate meaning" results in the responsibility of the respondent. He is not only faced with a question—no: he is faced with a decision, and in fact, an existential decision, but not an intellectual decision. What he must perform is not the "intelligere", not a factual realisation—but rather personal commitment.
>
> Reasons and objections are balanced like a scale; but the decision maker throws the weight of his own being onto one side of the scales. It is not knowledge which makes this decision, bit rather faith; but faith is not thinking minus the reality of that which is thought, but rather thinking, enriched by the existentiality of the thinker." (Frankl, 1993; Mensch vor der Frage nach dem Sinn, pp. 274).

In Logotherapy, to be a human being, means to be **free** to consciously decide what stand to take towards the events in our lives.

Dr. Frankl was very familiar with, and he frequently quoted the works existentialist philosophers, such as Spinoza, Socrates, and Kant. He referenced the works of Max Scheler, Husserl, Martin Heidegger, Carl Jaspers, and Ludwig Bingswagner, whom he knew personally. He was well acquainted with the works of Dostoevsky, Sartre, Marcel, Buber, and Nietzsche.

He recognised that within these philosophical writings, there was a large spectrum--ranging from presenting the human being in its reality, as is, and in phenomenologically describing the existence of the human being, without interfering as its reality unfolds--to outlining the categorical imperatives and maxims for human conduct--A range spanning from recognising the higher aspirations, and spiritual dimension of our being by the mystics (such as Marcel) to the chaos theory, and denial of purposeful order in existence, giving rise to existential "angst" (as in the writings of Sartre).

Frankl went beyond merely accepting philosophies without regard for their implications. He was known to have been a very thorough thinker, and wanted to present his theories precisely and accurately amidst all the possibilities for misinterpretation. Furthermore, with his emphasis on thinking, and thinking through, he opened up the possibility for others to do the same.

Logotheory rejects (1) Nihilism; (2) Reductionism; (3) Pan-determinism; (4) Solipsism; (5) Psychologism; (6) Spiritismus, and (7) Collectivism.

An outline of these concepts can be found in Frankl's writings (1996; 1994; 1986; 1981; 1972, 1967). Here we will briefly define each:

1. Nihilism: Is a viewpoint according to which "…traditional beliefs and values are unfounded and that existence is senseless and useless." [Merriam Webster Dictionary, 1994; p. 497].

2. Reductionism: "Considers higher order phenomena superfluous, as they are 'nothing but' entities existing along lower dimensions" [Ungar, 1999. p. 42] (For example, 'Love is nothing but a manifestation of the sex drive.')

3. Pan-determinism: "A doctrine that acts of the will, natural events, or social changes are determined by preceding events or natural causes" [Merriam Webster, 1994, p. 213]. For example, "…human behaviour is determined by genetic predisposition and environmental influences."

4. Solipsism: "The idea that our ability to perceive reality is only an illusion" (Frankl, 1996; p. 205). For example: We can never know anything for sure.

5. Psychologism: "Reducing the origin of all observable behaviour to the domain of the psyche" (i.e. past learning, and character; Frankl, 1996; p. 215). In its extreme forms, it leads to considering religion as a neurotic tendency, something to be cured, or eliminated, rather than understood.

6. Spiritismus: "The tendency to consider the dimension of the human spirit in isolation from the body and the mind" (Frankl, 1992; p. 136). In its extreme forms leading to ignoring one's biological and emotional needs.

7. Collectivism: The idea that the viewpoint of the individual is less valid than that of the majority. The viewpoint of the individual has to conform to the majority.

Instead, Frankl firmly advocated a **holistic** view, which is the key to understanding Logotherapy:

T*he whole of life is meaningful*, and *therefore, every moment in life is meaningful*. *As the whole of life has meaning, every person is intended, every persons' situation offers unique meaning possibilities to be fulfilled*. (Lukas, 1995).

According to Frankl, to be **free**, and **conscious**, is to be **responsible**: Responsible for our own life, and for the life of others, **to life**.

The existential decisions that beckon us to choose between what is meaningful, and what is not meaningful, do not only mean that we are free to respond. They mean that we are being **addressed** by life, and **expected** by life. In life, there is a meaningful answer—one and only one meaningful answer, for each unique situation that we find ourselves in—which we have to discover.

Thus, we answer to life with the existential decisions we make.

Logotherapy offers an unconditionally **positive** view of life. In fact, the *book Man's Search for Meaning*, ends with a Chapter on "*Tragic Optimism*" (which expresses the view that everything can be taken away from a human being, except the last area of freedom—the freedom to choose one's attitude towards the circumstances).

APPLICATIONS:

1. Suicide Prevention:

Perhaps nowhere is the belief in life's meaningfulness as relevant as in the attempts to avoid and to **prevent suicides**. Examples can be found in Frankl's case notes in *Man's Search for Meaning*:

> In the Concentration Camp, Frankl recorded how one of his first resolutions was to promise to himself that he will never commit suicide. Rather, he resolved to "live" his theories what he had that far recorded in the first manuscript of the book "*The Doctor and the Soul*." He also envisaged how his experiences will be relevant to post-war generations, and how his principles could be used in psychotherapy. Thus, he strengthened his initial resolve to remain alive (despite the slim chances of actually surviving his incarceration).

Also in *Man's Search for Meaning*, he reflected that the belief in life's meaningfulness was the single most important factor keeping his comrades alive:

> "As we said before, any attempt to restore man's inner strength in the camp had first to succeed in showing him some future goal. Nietzsche's words, 'He who has a why to live for can bear with almost any how,' could be the guiding motto for all psychotherapeutic and psycho-hygenic efforts regarding prisoners. Whenever there was an opportunity for it, one had to give them a why—an aim—for their lives, in order to strengthen them to bear the terrible how of their existence. Woe to him who saw no more sense in his life, no aim, no purpose, and therefore no point in carrying on. He was soon lost. The typical reply with which such a man rejected all encouraging arguments was, 'I have nothing to expect from life any more.' What sort of an answer can one give to that?
>
> What was really needed was a fundamental change in our attitude toward life. We had to learn ourselves and, furthermore, we had to teach despairing men, that it did not really matter what we expected from life, but rather what life expected from us. We need to stop asking about the meaning of life, and instead to think of ourselves as those who were being questioned by life—daily and hourly. Our answer must consist, not in talk and meditation, but in right action and right conduct. Life ultimately means taking responsibility to find the right answer to its problems and to fulfil the tasks which it constantly sets for each individual" (pp. 84-85).

Frankl believed that doctors should unconditionally support the life of their patients, according to the best of their abilities. Only if they believe in life's meaning and value unconditionally can they be seen as trustworthy by their patients. This is the essence of the *medical ministry*-- to be supporting of life under all circumstances.

2. <u>Treating Patients Compassionately, and with Dignity</u>:

This general attitude to life will then translate into how doctors approach their patients in everyday life. The whole of the attitude is manifested in small instances of the doctor-patient relationship, which is essentially affirming the dignity of life until its very end.

> According to an anecdote (Frankl, 1984b; p. 30), Sigmund Freud was once approached by a young lady who suffered from terminal cancer. She was very devastated by her condition, and worried about the meaning of her life. Upon listening to her cry and question the meaning of her life, Freud replied: "Ah, my dear young lady, your life had never any meaning!"...Later, in a letter to Princess Bonaparte, Freud remarked: "…the moment one questions the meaning of life, one is ill."

To understand how Frankl used a fundamental belief in life's meaningfulness, let us consider the case example of "Anastasia Kotek," presented in his book, *Psychotherapy and Existentialism* (pp. 95-98):

> Mrs. Kotek was an elderly lady who was suffering from incurable cancer. She had expressed a concern that her life will soon come to an end, and that everything she has done will be over, and forgotten. Frankl calls this awareness that we all have about our lives one day ending "Transitoriness of our existence." Mrs. Kotek was depressed to think that after her death, "nothing will remain." Frankl recognised this not only as a thought that had to be changed, to help to lift her out of despondency, but he wanted to help her see a new perspective that will give her the strength to have a stand toward her own death. The basic principle behind helping her to see such an attitude was dependent on shifting her belief from "all meaning is lost," to "all meaning is preserved."

> The conversation between Frankl and Mrs, Kotek took place in a lecture hall, in front of a large audience of the Poliklinic Hospital. Gradually, during the dialogue, Frankl invited Mrs. Kotek to recall an example of a person for whose achievement she had great respect. She mentioned the family doctor's work. This doctor died some time ago, but according to Mrs. Kotek, he "lived for his patients" in the way he cared for them. Frankl and Mrs. Kotek affirmed that "If anyone's life was meaningful, his life was." Furthermore, that nobody and nothing can take away this meaningfulness, not even death. The meaning remains even if not a single one of his patients can remember him any more.
>
> After this, Frankl invited Mrs Kotek to reminisce about her life. She recalled many happy memories, which Frankl affirmed. Then, he questioned her if anyone can blot her happiness out about all these things experienced, even the suffering that she went through with courage. Mrs. Kotek empathetically denied. "This remains, doesn't it?"-asked Frankl. Whereupon she firmly replied: "It does!" Whereupon Frankl concluded:
>
> "What matters in life is to achieve something. And this is precisely what you have done. You have made the best out of your suffering. You have become an example for our patients because of the way you take your suffering upon yourself. I congratulate you for this achievement, and I also congratulate to the other patients who have the opportunity to witness such an example. [*To the audience.] Ecce homo! [The audience bursts into spontaneous applause.*] " This applause is for you, Frau Kotek. *[She is weeping now.]* It concerns your life, which has been a great achievement. You may be proud of it, Frau Kotek. And how few people may be proud of their lives….I should say your life is a monument. And no one can remove it from the world" (Frankl, 1967; p. 98).

According to the account, Mrs, Kotek was greatly comforted by Frankl's words. A week later she died, but she was no longer depressed, but on the contrary, "full of faith, and pride."

> "Prior to this, she had felt agonized, ridden by the anxiety that she was useless. Our interview made her aware that her life was meaningful and that even her suffering was not in vain. Her last words were: "My life is a monument. So Professor Frankl said, to the whole audience, to all the students in the lecture hall. My life was not in vain…." (Frankl, 1967; p. 98).

We will return to Mrs. Kotek's example in a subsequent chapter on the practical application of logotheory, where we will examine fragments of the dialogue in more detail. However, reflecting on the example of the young woman, treated by Freud, and this elderly lady, treated by Frankl, consider the outcomes of therapy with these two patients, both seeking meaning in their lives.

POINTS TO PONDER:

* Admittedly, Frankl often wrestled with the question of meaning in life in his teenage years. He went through phases where he had intense doubts, followed by periods of search, to finally emerge as a man who gained wisdom through the years. There are challenging times which call to mind the question about the meaning of our lives. Have there been such difficult moments in your life? How did you handle such situations?

* When a radical shift from the view "*What can I expect from life*?" to "*What does life expect from me?*" happens, Frankl (1984) calls it a "***Kopernican revolution**.*" Such "Kopernican revolution" is often associated with finding meaning.

Can you recall an example of such crucial moment or event, a truly "*Kopernical Revolution,*" in your life, or the life of someone you know?

(2) Freedom of Will—Anthropological Foundations of Logotherapy:

The second Basic Assumption of Logotherapy, the "*Freedom of Will*", arose from a response to the deterministic views of the human being:

> "….Freedom of will is opposed to a principle that characterises most current approaches to human beings, namely determinism. In reality, it is opposed to what I call pan-determinism. After all, freedom of will means freedom of human will, and human will is the will of a finite human being. Human freedom is not freedom from conditions, but freedom to take a stand and to face whatever conditions might confront him" (Frankl, 1988; p. 16).

According to reductionist, and pan-deterministic views, human beings can be reduced to physical and psychological entities, within which domain behaviour can be explained as "nothing-but" the result of, for example, psycho-dynamic mechanisms, the satisfaction of physiological drives, etc.

As we mentioned earlier, the problem with the reductionist views, in the case of complex realities, and behaviours, is reducing them to lower levels, as "nothing but" expressions of processes in the mind, or physiological, instinctual realities, which can lead to not only a misinterpretation of the reasons of human behaviour, but to the denial of any higher reasons, in favour of causes, which can be easily manipulated.

The following example will illustrate the mistake:

> [In an experiment] Rats were shown various objects from which separated by an electrically charged wire net. First, a sexually deprived rat faced a rat of the opposite sex. The rat immediately crossed the net to meet its partner, receiving the shock. When put back to her original place, she did not try it a second time. The sex partner did not tempt her to experience the electric shock the second time.
>
> In a second experiment a starved rat was facing food. The rat crossed the wire a few times but gave up as soon as its worst hunger was stilled.
>
> In a third experiment a rat mother faced one of her young, separated by the electric net. The rat kept running to her young, regardless of how often she was put back, until she was dead.
>
> From these experiments it was concluded that the mother instinct was stronger than self-preservation, and this again, stronger than the sex drive.
>
> So far so good. But some psychologists drew conclusions according to their own concept of human nature. 'Ah,' they said, 'what human parents do for their children also is not done out of selflessness and love, but to gratify their own strongest drive, the maternal instinct. All sacrifices of a mother are made because of the pleasure she gains by gratifying her strongest instinct.' Mother love reduced to a simple gratification of a drive!" (Lukas, 1986; p. 16).

In the natural sciences, it is customary to take a look at objects from one dimension, and to generate results that can be applied to other phenomena. Also, it is in the tradition of good science, whether in medicine, social sciences, or physics, to identify the plain of one's examination, and to clearly outline the limit of one's conclusions.

Problems arise when **generalisations** are made across the dimension, or when the dimensions beyond one's scope of research are denied—such as when interpreting human behaviour solely on the on the basis of animal-experiments, which can not capture the complexity of the reasons for human behaviour.

The generalisation can be further illustrated with an easy demonstration, which will show how multifaceted phenomena need to be understood from several vantage points, otherwise the conclusion, or interpretation can be seriously flawed:

> Frankl (1996; p. 24) invites us to take a complex object, like a cone, and illuminate it with a flash-light from one side, we gain a projection of two different shades along two planes: One is a round shape, and the other is a cube. The two shades are clearly, two conflicting images. If we tried to predict the characteristics of the cone on the basis of the shades, we could be easily confused. For example, in one instance, we could mistakenly identify a ball from the round shape of the shade, instead of a cone. In the other instance, we could mistake the cone for a triangle, or a cube.

As this example illustrates, the complexity of multidimensional entities can not be understood along one or two selected planes. A complex phenomenon must be considered along several dimensions to be accurate.

Similarly, dissimilar things, when they are projected onto one, and the same dimension, result in an inappropriate view of reality:

> Consider for example, if we took a ball, a cylinder, a cone, and a flat, round object, and illuminated them with a flash-light from above. The resulting picture would be three identical round shades on a horizontal plane. On the basis of the shades alone, we could not guess which object corresponds to which shape.

The same problem happened in the conclusions of the rat experiment. An inference about parents' love was made on the basis of the rats' behaviour, and preferences to cross the wire, even at the cost of life. Rats are animals, and they obey drives. For a full anticipation of what would happen to humans, we can not rely on their example, as human **reasons** are so much more complex than biological-, or even psychological **causes**.

As we anticipate, the consequences of reductionism, nihilism, and pan-determinism in the sciences, or in everyday life can be far reaching, and serious, as they represent a distorted view of humanity. They can lead to offences against the dignity of people, and disrespect for their rights, and freedoms.

We do not need to go too far to look for evidence to prove this point. The cruel reality of the Second World War, just as many wars before, and since, time and time again, present exactly such "*experimentum crucis*," and with human "subjects:"

> In the Concentration Camps, for example, it was predicted that if one placed several hundreds of individuals under the same miserable conditions, deprive them of their liberty, food, and basic necessities of life, eventually all of them will behave in the same way; they will show no mercy in fighting for their survival, and will eventually come to behave like animals (Frankl, 1965).

However, as Frankl witnessed, "*this was simply not the case*."

In the chapter on "*The Psychology of the Concentration Camp*," [The Doctor and the Soul, p. 93-105] Frankl describes how there were individuals who managed to suppress their apathy and their irritability, and who walked about in the camp among the comrades, sharing a good word, and a last piece of bread, here and there. This was an example of self-sacrifice.

Or, the example of the young medical doctor, who, when the prisoners were in their bunks, held small speeches about the topics which concerned them, which enabled them to carry on the next day [The Doctor and The Soul, P. 103].

Dr. Frankl (1984) even goes on to cite the case of "Dr. J.", a Nazi mass murderer, and a truly "Mephistophelean being," who, after the war, managed to reform himself, and proved to be an exemplary comrade during his own prison sentence (*Man's Search for Meaning*, pp133-134).

> A diagram was put forth by Lukas (1984, via Barnes, 1995), which illustrates our possibilities to choose: to use a very simplistic, mechanistic model of the human being, we can be confronted by a negative input, or a positive input. In response to these two kinds of inputs, we have four "outputs" possibilities: (1) in response to negative input, we may respond with a positive output; (2) in response to a negative input, we may respond with a negative output; (3) in response to positive input, we may respond with a negative output; and (4) in response to positive input, we may respond with a positive output. Two of these response possibilities are automatic, and do not change the world: the negative response to negative output; and the positive response to positive input do not alter was initially "given." The response of a negative output, in response to a positive input, even inflicts further suffering on others. Only one of these possibilities creates something in the world that was not there before: A positive output in response to a negative input. However, this response alternative may be the most difficult to achieve. --The point of this illustration is to show that ultimately, the decision rests with us. Even if we consider our predispositions, we are not automatically pre-programmed!

How can we explain the possibility for human beings to **choose** their response to their environment?

Frankl's existentialist view starts with considering the **nature of human existence**: In the search for a meaningful ways of responding to the environment, human beings have not only their genes, and their learned behaviours to count on. These are important. However, **beyond** them, human beings also have to decide in favour of **values** that they want to act on. In the moment that they choose a value, for example, self-sacrificing love for the sake of their children, they become this value through their actions. They actualize this possibility in reality.

Existence, in a human sense, means rising above a two dimensional plane, from what is given, to "what can be." This is why Frankl stated that:

> "Existence is a way of being, characteristic to human beings, which is not a **factual being**, but a **facultative way of being**. It is a not an unique-and never changing way of being, as neurotic people tend to misinterpret it, but the possibility to always change oneself." (Frankl, 1994, p. 61).

Human beings are the only creatures who are can reach beyond themselves in the search for purposeful goals and values. They have a body, and a mind. But beyond, their bodies and minds, they are equipped with *Freedom of Will* to explore, and to decide, the direction of their actions, even if this means acting in the belief of something that is greater than them.

The key to understanding Frankl's concept of the *Freedom of Will* is the inclusion of a **third dimension in human existence** (*Tertium Datur*), aside from the planes of body and mind. While in body and mind we are determined, and/or influenced by physical, and psychological mechanisms, there is a dimension--a uniquely human dimension—which allows us to reach beyond ourselves in the search for meaning.

This dimension is called the **Noetic dimension** [Noos--from the Greek word for spirit, literally translated as "Mind"]—hence, Frankl's notion of the **Dimension of Spirit** is a unique coordinate in the *Anthropological View* of human beings (Ungar, 1999, p. 49). This particular **anthropological view** is summarised in Frankl's **Dimensional Ontology** (Frankl, 1975; 182-186):

> When we project human beings along one dimension, we arrive to a picture of our biology, and physiology: Complex biochemical, neural, etc. processes are responsible for the functioning of our body. These processes are influenced by natural laws. They can be more or less substantiated, touched, measured, altered, predicted, or controlled.
> They are influenced by or genetic make-up, and function in order to maintain a healthy equilibrium, and protect our organism from harm.
>
> Our psychological processes are even more complex. They are the sum of all of our cognitive abilities, such as attention, perception, information processing, cognitive schemas, affect, which are directly influenced by the environment and learned behaviour. They are more difficult to substantiate, and are very sensitive to environmental changes. They are responsible for our ability to assimilate new information, and to accommodate to information in our surroundings, in order to arrive to a temporary state of rest, or homeostasis, serving the optimal functioning of our organism.
>
> Our existence in our bio-psychological domain is more or less determined. Namely, it is subject to environmental and genetic influences, the laws of physical causality and chemical processes. For example, in the dimension of the psyche, our character is shaped by past experiences and new learning in the environment. Therefore, in terms of their possibilities, both our bodies and minds are **closed systems**, whose functioning can be easily interrupted by external or internal factors, such as chemical imbalance, disease, or death.
>
> Plants have a physiology, and animals have a physiology, and psychology. Beyond biology, physiology, social realities, or psychology, however, human beings exist along another unique dimension. This dimension is the dimension of spirit.

Dr. Frankl used the Greek word "*Noos*"--Mind--to avoid confusion with the religious connotations of the English translation of the German word "Geist" as "spirit." He also wanted to differentiate spirit from a general understanding of the "mind" as a psychological function related to the processes of the brain, and the term "soul," used to refer to one's psychology and spirituality. Originally, he used the word "spirit" to refer to a "**specifically human dimension**" (Frankl, 1975; p. 90), present in all persons, regardless of their religious, or spiritual orientation, or, even atheistic bent.

The *Dimension of the Spirit* opens up a perspective in other psychological models of existence, human nature, and personality, with implications for psychotherapy. For example, as illustrated in the article "*Transcendental Locus of Control,*" the dimension of the human spirit adds another dimension to Rotter's original idea of Internal-, and External Loci of Control (Mendez, et al., 2003).

While we will consider the resources of the human spirit in another section, here we will highlight a few of its qualities:

* The spirit, according to Frankl's logotherapy (1975), is a not a substance. It is a dynamics.

* The spirit can not be divided, reduced, or duplicated.

* The spirit as a whole is greater than the sum of its parts.

* Spirit is the essence of a person. It is, with each person, an entirely new creation, not inherited from one's parents, or encoded in the genes.

* One of the resources of the human spirit is conscience. Conscience is not super-ego. Beyond the super-ego, it is a "meaning-organ," which means that, like an internal compass, or antennae, it is always oriented to discovering meanings (Lukas, 1989; p. 22). Thus, conscience keeps a link between our Spirit and Meaning.

* Body and mind (physiology and psychology) refer to what we "have." Spirit refers to who we essentially, and existentially, "are."

* Our body and mind exist within the constraints of time and space. They are basically a closed system, which is more or less determined, constrained, vulnerable, and subject to illness and disease. (There is an essential parallel between the susceptibility of the body and the mind. This is called "Psycho-physical Parallelism;" Frankl, 1975; p. 98-99).

* The spirit is not constrained to here-and-now. Spirit is essentially "trans-spacial," and "trans-temporal" dynamism, spanning the past, and the present in the search of meaning. It is essentially open to the future. It can not be damaged, or destroyed, and it does not become ill. (As opposed to the body and the mind, the spirit can not become ill, and as a potential, it is ever present. This is called Pscho-Noetic Antagonism; Frankl, 1975; p. 100).

* The body and the mind are instruments of the human spirit, through which the spirit expresses itself.

* There are conditions and circumstances in which the spirit can not come to expression, or, its dynamisms are limited; such as in the case by immaturity, senility, illness, or disease. However, the human spirit as a potential is always present.

* Spirit is that dimension through which human beings can rise above their psychological and physical dimensions, and take a stand towards it. In other words, to exist means "…to come back to oneself by rising above, and beyond oneself, and ones' circumstances" (Frankl, 1994, p. 61).

* Therefore, our spirit is the source of our ultimate freedom.

* Our potential freedom "…may be temporarily limited by illness, immaturity, senility" (Lukas, 1998, p. 4), or can be even blocked. However, this does not change its fundamental existence.

In the light of the *Dimensional Ontology*, the principle of the *Freedom of Will* asserts that human beings have a will. They can activate their will freely, albeit they have to live with the constraints of being human: being mortal, and fallible.

Within the limitations of being vulnerable, fallible, and finite human beings, we are essentially free to distance ourselves, and to rise above, and beyond our instincts, genetic inheritance, and environment. We can choose our response to our genes, upbringing, to events of fate, and even to our own selves.

Our freedom and responsibility extend to the point that our conscience allows us to discern meaning possibilities, with the provision, that it is the conscience of a fallible and mortal human being (Frankl, 1965).

We need not fight against our instincts, drives, genetic inheritance, and environment all the time, and at all costs. For, as much as we express ourselves "despite," or act "in-response-to" our physical and psychological realities, so we become ourselves exactly with "help of" and "through" our physical, social, and psychological realities (1994).

APPLICATIONS:

1. Considering One's Response to Illness:

In the Chapter on the *Psychology of Melancholia* [The Doctor and the Soul, 1986; p. 200] Frankl expresses the view that in medicine, and in psychotherapy, there are two pictures that doctors and therapists need to pay attention to. There is a picture of the complaint, or the illness itself, which has its own origins, causation, or reasons, and manifestations in symptoms. The picture regarding the *origin* of an illness is called **Patho-genesis**, and the *manifestation* of the illness in its symptoms is called "**Pathodizee**."

Yet, there is a third picture that emerges to the clinician upon considering how the patient **handles** the illness, or **responds** to the symptoms. This picture is called "**Patho-plastic**."

Not every illness manifests itself the same way in every individual. Or, in other words, not every person responds to the same illness the same way.

How people respond to their illness, or to their symptoms already informs the clinician something about the stand they take toward their illness, and about their person, and attitudes. While these attitudes can be healthy and even heroic, some patients' attitudes may be unhealthy, and inflict more suffering on them, in addition to suffering from their condition. Regardless if the condition is treatable or not--and the intention is to intervene to cure whenever possible--an unhealthy attitude needs attention, and can be changed, which alleviates some suffering that can be spared.

2. Holistic Diagnosis:

The clinician has to make a careful judgement about the somatic, psychological, and spiritual dimensions, which are involved in the **diagnosis** and **treatment** of a patient.

Complementing somatic complaints with a picture of the relevant social, psychological, and spiritual factors may result in a whole new approach to treatment.

So is it also relevant not to neglect the somatic-, psychological-, or social correlates of a spiritual concern.

Diagnostic considerations for treatment are summarised in Frankl's book: *The Doctor and the Soul*, 1986; Psychotherapie in der Praxis [*Psychotherapy in Practice*], 1991; Psychotherapie vur der Alltag [*General Psychotherapy*], 1992; and Theorie und Therapie der Neurosen [*Theory and Therapy of Neuroses*], 1993.

The following selected case examples illustrate that a three-dimensional interpretation of human beings, according to Frankl's *Dimensional Ontology,* which allows to involve, and to affirm patients in their efforts to live a meaningful life:

1. Frankl, V. E. (1998). Turning Suffering Into a Triumph. The International Forum for Logotherapy, 21(1), 59.

This is an example of a Carmelite sister, who was suffering from psychotic depression. Her suffering was increased when her superiors had told her that as a Carmelite Nun, she should not be depressed. Still, behind the afflicted body and psyche, Frankl discovers the spark of the human spirit yearning for meaning through a successful recovery. The example illustrates the power of the human spirit, which is a resource in therapy:

"Sister Michaela suffered from severe depressions and had considered suicide. She particularly suffered from guilt based on her belief that as good Christian her faith should be strong enough to conquer her sickness. Frankl diagnosed her condition as endogenous depression and prescribed appropriate drugs. But he also stressed that her depression had a primarily organic cause; hence that she was not responsible for it. Thus the fact that she suffered from the depression was not due to any failure on her part, but how she took it could constitute a mental and spiritual achievement. After a few therapeutic sessions the patient was relaxed and in better spirits. She remarked, "I am at peace with myself and grateful. I have accepted this cross." She later showed Frankl an entry in her diary, which he treasures as a testimony to the defiant power of the human spirit. It reads in part:

I am exposed to unknown forces which overwhelm my will--quite helplessly exposed am I. Sadness is my steady companion; whatever I do, it weighs me down like lead upon my soul. Where are my ideals? Gone--as all the good and beautiful things for which I used to strive. Nothing but yawning boredom fills my heart. I live as if thrown into a vacuum, and at times not even pain is accessible to me. In this distress I call God, the Father of all, and even God is silent. I wish for only one thing--to die. If I had not the faithful awareness that I am not the master over my life, I would have ended it many times; but through this awareness the bitterness of my sufferings is suddenly transmuted. For, a person who assumes that his life must consist of stepping from success to success is like a fool who stands next to a building site and shakes his head because he cannot understand why people dig deep down when they set out to build a cathedral. God builds a temple out of each man's soul, and in my case he is just starting out to excavate the foundations. It is my task to offer myself to His excavations [also cited in Frankl, The Will to Meaning; 1969, p. 132, cited in Fabry, 1994, p. 50]."

2. Lukas, E. (1998). Case Study. Two and Three-dimensional Interpretation. Logotherapy Textbook. University of Toronto Press, Canada. Pages 38-46.

This is the example of a man who had to attend regular massages in his recovery from an injury, and was feeling guilty, and afraid of feeling sexually aroused, when he wanted to remain faithful to his wife. The example illustrates how understanding his *true self* helped him to regain his confidence, and to realise that while he does not control the physiological reaction of his body, it is the action that he chooses to take in response to this automatic reaction what counts—where he had no reason for guilt feelings, as he had stayed faithful to his wife in the past. His present concern for his reactions showed that he had truly cared for his wife.

POINTS TO PONDER:

* Whenever we speak of freedom, such as the *Freedom of Will*, one is reminded of fate. What is "freedom," and what is "fate?" On a sheet of paper, make two columns: One stands for "Fate"—all those events which we can not change. The other column stands for "Freedom"—what is in our "hands" to change? List all the points that come to you mind under both columns. The columns will now give you a sense of your respective areas of personal freedom, and fate.

* Every profession carries a summary of codes and relevant guiding principles. These reflect the fundamental attitudes and assumptions of the professionals who provide the services. For example, the first principle of the *Socratic Oath*, relevant for health care professionals is: "*Primum non nocere*!" ("*First,* d*o no harm*!")

A three-dimensional view of human beings helped Frankl to develop guiding principles for logotherapists. His **Psychiatric Credo** sounds: "*The human being can be disturbed, but never destroyed"* (Frankl, 1994; P. 86; Frankl, 1984; p. 134-135). And his **Psychological Credo** states: "*The human being is able to respond to suffering, and illness"* (Frankl, 1994; P. 96).

How would you conceptualize your own personal mission statement, and credo?

(3) The Will to Meaning—Logotherapy as a Theory of Psychotherapy:

"*Logos*" is a Greek word. It can be translated as "*Reason*," or "*Meaning*" (Frankl, 1984b; p. 74). The literal translation of the word logotherapy is "**therapy through meaning**" (Frankl, 1984). It can also be translated as "**healing through meaning**," (Frankl, 1984b; Introduction). Through its tenets and principles, logotherapy is a meaning-centred psychotherapy.

The existential background for the *Will to Meaning* is related to the nature of human existence: No other creature, but human beings in the history of evolution reached the point of being aware of, and confronted with life's finiteness, and mortality (Frankl, 1972).

In Frankl's view, exactly the ability to contemplate, and to be aware of life's ending, make life precious. Exactly in the knowledge that our life is finite makes sense to act, and to find what is meaningful becomes urgent.

However, not everybody agrees: As you may recall from Frankl's memoirs, in his elementary school years, one of his professors described life as a slow oxidation process, with no end goal in sight, but slow disappearance, and perishing, upon which the young student raised the question: what is then the meaning of life? From that time on, Frankl started to develop a philosophy that became part of logotherapy.

The motivation concept in the *Will to Meaning* means that every human being is inspired by a striving and yearning for meaning: (Lukas, 1998, p. 5):

> "It is seen as our main motivation for living and for acting, and it goes deeper than the will to pleasure and power. When we see meaning in life, we are willing to endure any suffering. On the other hand, if we see no meaning, even a life of well-being will seem empty and futile" (Barnes, 1995; p. 9).

Everybody wants to be successful, and to accomplish something worthwhile in life.

The *Homo Sapiens*, writes Frankl (1994; pp. 131-132), sees, and thinks only in terms of **success** and **failure**. This is a popular view among people who are interested in increasing their wealth, competing against others, attaining prestige, etc.,--all those who are judgemental, and evaluate human achievements according to their consequences, the opinion of the majority, or, according to how much gain they will have at the end. This dichotomous way of measuring and evaluating the degree of our success can make one vulnerable to unpredictability, or happenings beyond our control.

Aside form the thinking of the *Homo Sapiens*, Dr. Frankl (1984) introduces the thinking of the *Homo Patiens*—the suffering human being, as another dimension, vertically aligned with the axis of "success-or-failure-thinking." This Axis has to do with the **meaningfullness** of an effort. At the one end of this Axis, we find "**meaning**," and at the other, "**despair**":

For the *Homo Patiens*, the suffering human being, "failure" becomes tolerable if it is met with meaning. Even if his or her efforts were not followed by success, but the effort was the pursuit of a meaningful task, that person will be saved from existential despair. On the other hand, even the most successful person's life will feel empty and futile without a sense of meaning and purpose.

These two axes are known as "**Frankl's Cross**" (1994; pp. 131-132), in which we can conceptualise four areas: (1) Success, which is coupled with meaning; (2) Success which still feels "empty", and leads to despair; (3) Failure, which is coupled with meaning; and (4) Failure with no sense of meaning, which leads to despair.

We could list several examples for each of the quadrants of "Frankl's Cross." For our present purpose, let us consider the ones emerging from the following account:

> Frankl called Dr. Jerry Long the epitome of "logotherapy lived." Dr. Long was a clinical psychologist, and long-time friend of Viktor Frankl. He became paralysed from the neck down when he was in his teens, after a diving accident (Long, 1982). During the Twelfth World Congress of Logotherapy, in Dallas, in 1999, he reminisced about his accident, and his friendship with Dr. Frankl over the years. He recalled scenes from his rehabilitation at a hospital clinic in the United States. Several years after his discharge, he reportedly re-visited the unit where he was first admitted after the accident, and took the opportunity to talk to the nurses, and to inquire what happened to the other patients who were hospitalised with him. To his great shock, and surprise, he learned that among the patients who were in the same recovery room as he, he was the only one still alive. Several of his fellow patients, who were in a similar condition, recovering after near fatal accidents, have since committed suicide. They have taken lethal dosages of medication, or ended their lives in other ways, sometimes with help from their caregivers.
>
> "I broke my neck, it did not break me" (Long, 1982; p. 58)—wrote Jerry to Viktor Frankl, from his hospital bed. Dr. Long spoke openly about how he coped with pain and managed to survive the accident. On the basis of his life experiences, his training, and work, he taught several courses on psychology and logotherapy. At the Eleventh World Conference, he presented his article "Logotherapeutic Transcendental Crisis Intervention" (1997). At the Twelfth World Conference he taught that: "Physician Assisted Suicide is a Choice Against Meaning" (1999). Published shortly after his death in 2002, his article affirms that "*Man's Search for Meaning*" is a Gift. His closing words are: "…The past is our soul and anchor. Do not let time wash it away. It is our bridge to the present. Do not let ignorance tear it down. And, it forms our guideposts to the future. Do not let fear shred it apart" (Long, 2003, p. 80).

Like Frankl (i.e., 1984), Dr. Long's always taught that to pursue happiness, or success, or power alone, are ends in themselves. They are self-defeating, and they are never attainable. The more one aims to be happy, the more happiness runs away. For happiness can not be directly attained, it can not be pursued. Rather, it must *ensue* as the consequence of having experienced, or accomplished something meaningful, or having met one's fate with a courageous attitude.

In fact, the degree to which people aim directly for attaining power, success, happiness, or even control, instead of fulfilling what is meaningful, is the extent to which they are susceptible for neurosis, and further suffering:

> "If one's goal is to be happy, than that goal can never be fulfilled. The moment one aims at happiness, one misses it. And, the more one thinks about happiness [hyper-intention], and reflects on happiness, or to the extent to which he or she is happy [hyper-reflexion], happiness vanishes; it gives place to attention and worry. (Frankl, 1975; p. 10).

Frankl continues to explain:

> "To truly exist, means to empty oneself for the sake for a higher purpose. Man truly finds himself when he is able to lose himself to such a task. Indeed, Kierkegaard was right when he said that 'the door to happiness is s one way door; it opens to the outside (Frankl, 1975; p. 10)."

Dr. Long's life could have been easily considered a "failure." Instead, he witnessed that the *Will to Meaning* is a fundamental motivating force, evidenced in all individuals. It is present even in the case of severe mental illness, such as endogenous psychoses, schizophrenia, or bipolar disorder. It is a resource which is indispensable in the prevention of suicides, and any therapy.

Whether as a **specific therapy** in the treatment of existential frustrations, or sense of meaninglessness; as a **non-specific therapy** in the treatment of anxiety disorders, endogenous conditions, or physical illness; as well as in the prevention of mental health problems, and in fostering mental health and well being, logotherapy relies on every individuals own *Will to Meaning*.

APPLICATIONS:

1. Utilizing the Will to Meaning in Treatment:

The *Will to Meaning* is there even in the case of serious physical, and mental disorders, although, at times, it may appear "masked" by pain, or the symptoms of the illness. The trained clinician must always look, and listen carefully to the words of the patient, and find out from them what it is that they hope for; and what is it that keeps them "alive." This can be a concrete goal, such as regaining their health, raising a family, being there for someone, or finishing a yet unfinished task. In each case, it is something, or some way in which the individual's mission becomes highly personal, unique, unrepeatable, and irreplaceable. Thus, the *Will to Meaning* is the clinician's strongest ally against apathy, and a healing resource, complementing other forms of treatment, wherever it is needed. In the case of choosing a response to an illness, it springs forth from the spirit of the person, and is, therefore, aptly called the "*Defiant Power of the Human Spirit*" (Frankl, 1984; p. 102,133).

The following are a few selected articles that illustrate the relevance of the *Will to Meaning* in the case of severe physical, emotional, or mental health problems (Abrami, 1997; Giovinco, 1994; Haines, 1986; Lantz, 1984; Lazar, 1984; Lukas, 1993; Simms, 1979; Sjolie, 2002; Stefanics, 1989; Ungar, 2002).

2. Crisis-Intervention:

Viktor Frankl (1986) maintained that even the person who wants to commit suicide, or self-harm, believes in some kind of meaning, otherwise he or she would not be able to move a finger to harm him or herself. From a human, medical, and ethical perspective, this meaning is not the right meaning for the situation. Existentially, the person's conscience may have been clouded by the symptoms of depression, so that its healthy orientation to finding the right meaning of the moment has been thwarted. The therapist in these situations has the responsibility to help the patient see meaning and to prevent suicides at all costs.

It is not always easy to detect the intention for suicide. Most of the time, patients may talk about wanting to harm themselves. If they are truly depressed, they also look for the mental health professional's direct question "*Do you have thoughts of harming yourself*?" as helpful in uncovering such intents. They do not resist hospitalisation.

However, what is more difficult for the mental health professional is to avoid not noticing the tendency for self-harm, if the intention can be potentially there, and is only temporarily suppressed.

For such cases, Frankl devised another question: After asking patients about whether they are planning to harm themselves, and the patient who has been brought to his attention with suicidal ideations gives a negative response, he follows up by inquiring "*Why not*?" The person who is able to activate his or her will to meaning, and has answered truthfully to the clinician will pint out some of his or her reasons, such as tasks, responsibilities, commitments, etc. On the other hand, the person who wanted to deceive the clinician, only to have his or her plans to commit suicide thwarted, will have no ready answer for this question. In such cases this person's will to meaning has been blocked, and his or her restless silence will indicate hopelessness, and a belief that he or she has nothing to live for.

After stabilising patients' condition, their *Will to Meaning* can again be evoked. To the point that, even before having concrete goals, patients can be addressed by therapists in the following appealing way to their inner strength: "*We really wish to help you, and to stay with you as long as you are not feeling better, and we can be sure that you will be able to handle some of your responsibilities. However, for that we will have to wait patiently, until the treatment takes effect. We will work with you together*."

And later on, upon discharge, one cam appeal to patients' sense of responsibility: "*If you commit suicide while you are in my care as an outpatient, than me and my associates will be in a very serious trouble for having let you go and stay our of the hospital. We can get a fine, we may even loose our licenses to practice. Not to mention the guilt feelings that we will have that we let you go out of the hospital*." The clinician, following the regular clinical routine for assessments, evaluations before discharges may follow up by saying: "*For this reason, it will be really important that you check in with your family physician, inform your nurse, or relative when you feel the symptoms of depression again, and when you feel that you want to harm yourself....*"

Related sources to this topic include (Boschemeyer, 1989; Freeman, 1995; Long, 1997; 2000).

3. Neurotic Pursuit of Power, Success, or Pleasure:

Whenever the *Will to Meaning* is substituted for the *Will to Pleasure*, or the *Will to Power*, or the *Will to Success*, a dangerous spiral of hyper-reflection on one's performance and hyper-intention can result (Frankl, 1986). Logotherapy has two specific tools in the techniques of de-reflection and paradoxical intention, to counteract hyper-attention and hyper-intention. As a non-specific therapeutic tool logotherapy's **Modification of Attitudes** can be used to complement any therapy where the strength of one's *Will to Meaning* is called for. We will discuss these methods in a subsequent section.

POINTS TO PONDER:

* Reflecting on your own experiences, has there been a time in your life when what you have done, seemed a "failure" to others, yet, you knew that it was the right thing to do?

Was there a time when you really wanted something, and it did not happen the way you wanted it to be?

Was there a time when, what initially seemed a "failure," turned out to be a "success?"

Or, the other way around, was there something that you thought will be a "success", and turned out not to be?

In each of these instances, what was the role of having a sense of meaning in your life?

* According to Hiroshi Takashima (1987), the founder of the Japanese Society for Logotherapy, the concept of the '*Will to Meaning'* reaches back thousands of years, as evidenced from three sacred objects unearthed from the Imperial Household in Japan. Among these sacred objects are a necklace, symbolizing pleasure; a sward, symbolizing power; and a mirror, the symbol of self-reflection and self-transcendence toward meaning.

What symbols or metaphors would you attach to these concepts?

* Dr. Lukas once explained that to search for happiness instead of meaning is like clutching a snowball: the more one hangs on to it, the faster it melts and fades away.

What is your opinion?

Chapter III: Concepts in Logotherapy

Below we summarize the major tenets of logotherapy which underlie its caring and compassionate approach to health care.

1. The Plurality of Sciences and the Oneness of Man:

Based on considering the characteristics of the human spirit as an in-divisible and un-summable entity, in 1972 (pp. 108-118), Frankl summarised "*Ten Theses on the Human Person*," applicable to all human beings in all circumstances.

Below, we briefly list these points which appeared under the title "*The University of Sciences and the Oneness of Man*" and are also known as Frankl's advocacy for "**Monanthropism**:"

* Every person is an Individuum;

* Every person is not only in-dividuum, but also in-summable;

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

* Every person exists in spirit;

* Every person is existential;

* Every person is basically self-directed;

* Every person is a united whole (of body, mind, and spirit);

* Every person is dynamic;

* Animals are not persons;

* Human beings understand themselves to the extent that they transcend (reach beyond) themselves.

2. Person and Personality:

A person, who is in essence a spirit-being, **can not be divided** (Lukas, 2000). A person as a whole is **more than a sum of its parts** (Lukas, 2000). Because of the dimension of spirit, every person is basically free (Frankl, 1967; 1969; 1972; 1975).

A person is not identical with a character, or illness (Lukas, 1989; 1998). During our lives, we develop our personality. This happens through our upbringing, and choices, and the successive realization of our potentials, which leads to building patterns of behaviour (Lukas, 1989; p. 67).

Developmentally, spirit is what we are in essence (Frankl, 1972; 1975). From the moment of conception, the resources of the human spirit exist as a potential. However, the mind and body have to develop to become accurate instruments for realizing our full potential (Barnes, 1995).

This is how we can explain that the resources of the human spirit are not fully available in early childhood, until sometime near adolescence; that they can be temporarily unavailable, or blocked by illness, such as in the case of psychotic illness; or unable to come to full expression, such as in the case of immaturity, or senility.

Otherwise, adolescence is usually considered the point when maturity allows to make crucial decisions and to "shape" ourselves (Lukas, 2000). This maturity allows the spirit to express itself in the form of a conscious search for one's purpose in life.

To the extent to which our dimension of spirit is free to express itself, and we have an area of freedom, we can choose to break a previously built pattern, and to build new patterns (Lukas, 1998). We are not pre-determined.

However, illness can block our ability to access the resources of the human spirit fully (Lukas, 1989; Barnes, 1995; Barnes, 1995b). Also, our spirit may not be able to fully express itself, such as, for example in the case of a deep coma, when the faculties for the usual expression of the spirit are not available.

Yet, to the last breath of life, spirit exists in union with our earthly body, and therefore meaning is still potentially available. This gives each person unlimited dignity, no matter what their medical or psychological condition may be (Barnes, 1995b).

3. Freedom and Responsibility:

With freedom and conscious awareness comes a human persons responsibility in life, and responsibility to life (Frankl, 1967; Lukas, 1995, p. 164), to choose that which is intended by life: to answer that question which life poses in every moment, and to chose that response which was meant, the only one response, which, when found is recognised as "**right**" (Frankl, 1975; p. 119; 1981).

4. Freedom and Fate:

There are two areas in life that confront us. One is an area which we have little, or no control over, which is our area of "**fate**" (Lukas, 1995; p. 164). The area of fate applies to all our genetic makeup, physical abilities, limitations, events of fate, accidents, our upbringing, our current situation, as it is. This area implies no responsibility, for there is not freedom, or very limited freedom available.

Because of our dimension of spirit, however, every area of "fate" is complemented by an area of "**freedom**" (Frankl, 1994). This area is last, but not least in the depth of the spirit, where we can choose the attitude with which we respond to the area of fate (Frankl, 1965; Frankl, 1994; Barnes, 1995b).

5. Response-ability:

To be human means to be **free**, **responsible**, and **conscious** (Frankl, 1967; 1972). The latter, conscious awareness is required for the recognition of meaning (Lukas, 2000).

Only the capacity to recognise meanings, and to have insight into one's actions, and its consequences can lead to freedom, and is the ground of responsibility.

Freedom, responsibility, and the ability to perceive, and respond to meanings determine one's existential **merit**, or **guilt** (Frankl, 1967; Lukas, 2000).

Merit and guilt are uniquely human capacities, and existential phenomena that should not be explained away (Lukas, 1989; 1995; 2000).

6. Meaning:

Lukas (1995) noted that the meaning of life ("Logos") may be at the same time both infinitely abstract, and exceptionally concrete. In both of these instances, meaning can be defined as "*truth, beauty, and goodness*" that which is meant to be, and that which we in the depth of our hearts recognise to be true.

[According to a definition, "Logos" is "*Divine Reason*" (Russell, 1996; p.293) the *Intellect of God* (Russell, 1996; p. 294*)*. However, for people in general, and even to atheist persons, Frankl maintained the meaning of "meaning" as "truth" Frankl, 1975; p. 119; "higher values" that have to be lived (Frankl, 1975; p. 121; "that which is intended by Life;" Frankl, 1965, 1967; 1975]

In logotherapy, generally three levels of meanings are distinguished.

For the type of meaning which can not be attained by us, "…except by reaching in faith into the transcendence of God" (Lukas, 1995; p. 14), Frankl (1996) coined the term "Supra Meaning" or "**ultimate meaning**" (p. 75). This type of meaning is the most abstract as it can be likened to a general organising principle in the universe. According to Frankl, it is useless to speculate about ultimate meanings because they are beyond our human comprehension. The theory of such ultimate meanings, explains Lukas (1995; p. 14) affords the possibility that even those elements in this world which our intellect would have declared as 'senseless'—like for instance the existence of evil, the inescapable fact of ageing and dying—might in another dimension have meaning.

Another way to approach the reality of *Ultimate Meaning* is to say that it is useless for us to intellectually ponder "why" 'senseless' things happen. What is more productive is to ask "what" particular task life is challenging us through overcoming such tragedies.

Tragedies in themselves are not meaningful, and the human suffering in response to them is real. However, our response to tragedies can save meaning for eternity.

The next "category" of meanings, according to Frankl (1996b) is open to humans, but not available to animals. This category of meanings has to do with our uniquely human ability to review, and to preview our lives, and to reflect on the specific **meaning contents of our lives**. Such meaning, during the course of a lifetime can be seen in experiences, in *being there for someone;* or in tasks, such as *being there for something (Lukas, 1995; p. 14).* Being there with the whole of our abilities in life is also a value that we can experience as our personal response to life.

The most concrete type of meaning is the present meaning, the "**meaning of the moment**" (Frankl, 1967; p. 55; 1975). Here we encounter the meaning, which is the "pacemaker of our being" (Frankl, 1967; p. 26). The relevance of this type of meaning is that it is person, situation, and time specific. In other words, it is a unique, personalised, and unrepeatable call.

Personal meanings reflect, and become part of one's meaning in life, and of ultimate meanings. Personal meanings are also relative. However, they are not subjective.

Rather, they are trans-subjective realities which stand in relation to a person (Frankl; 1967).

Our task, says Frankl (1967), is to discern that meaning which relates to us, in our particular situation:

> "Each man is unique and each man's life is singular; no one is replaceable nor is his life repeatable. This twofold uniqueness adds to man's responsibleness. Ultimately this responsibleness derives from the existential fact that life is a chain of questions which man has to answer by answering for his life, to which he has to respond by being responsible, by making decisions, y deciding which answers to give to the individual question. And I venture to say that each question has only one answer—the right one!
> This does not imply that man is always capable of finding the right answer or solution to each problem, or finding the true meaning of his existence. Rather, the contrary is true; as a finite being, he is not exempt from error, and therefore, has to take the risk of erring. Again, I quote Goethe who said: 'We must always aim at the bull's eye—although we know that we will not always hit it.' Or, to put it more prosaically: We have to try the absolute best—otherwise we shall not even reach the relatively good (Frankl, 1967; p. 31).

8. Conscience:

According to Frankl (1996b), it is impossible to separate the meaning of the moment from the meaning of the whole. As the meaning of the whole cannot be fabricated, so it is also impossible to invent concrete meanings and the meaning content of one's life. Meanings have to be "**discovered**" and "**decoded**" (Lukas, 1995; p. 16) from among a number of alternate possibilities. True meanings are the ones which "fit" the design of higher meanings, the meaning of our lives, and the ultimate meaning of life.

This discernment takes place in the depth of the spirit, through one's conscience:

> "Through the conscience of the human person, a trans-human agent per-sonat—which literally means, "is sounding through" (Frankl, 1975; p. 53).

Conscience is one of the resources of the human spirit. It is the **Voice of Transcendence** (Frankl, 1975; p. 54).

It is a specifically human phenomenon, and not the mere consequence of learning processes, father images or anything else. Although conscience is influenced by training ad outside influences, it can not be reduced to these influences.

Frankl defines conscience as an intuitive capacity to find out, to "sniff out" the unique meaning inherent in a situation, "what is meant" in a specific situation." He also compared our conscience to an "**inner compass**," which points us in the direction of meaning.

When conscience is projected into the psychological dimension, it appears as a phenomenon similar to the super-ego.

However, Frankl's notion of conscience is not identical with the super-ego ("Uber-Sich") in Freud's theory. According to Freudian psychoanalytic theory, the super-ego arises out of a process of learning, internalising parental, and societal rules and restrictions. Its function is to impose rigid rules on the individual.

In Frankl's terminology, conscience functions in addition, and **beyond the super-ego**, as a dimension which allows to reach from the self, into the transcendent (supra-ego, or "Uber-Ich;" Frankl, 1994; p. 99).

Frankl illustrates his thesis that conscience is a specifically human phenomenon with the following story:

> "A typical reductionist theory considers the conscience as the outcome of a conditioning process. A dog that has soiled the carpet and slinks under the couch with its tail between its legs acts indeed as a result of a conditioning process. It displays anticipatory anxiety, a fear of getting punished. The human conscience must not be reduced to such a level. As long as human conduct is determined by fear of punishment, hope for reward, or the wish to comply with the superego, the genuine conscience has not been heard at all (Frankl, 1984; p. 55-56).

> "Frankl considers it "psuedomorality" when we act moral only because we want to live in peace with our superego. True morality begins only when we make a decision to act for the sake of someone or something, not merely for ourselves—be it to have a clear conscience or to get rid of an irritated super-ego." (Fabry, 1994, p. 66).

This implies that **self-transcendence** results in a clear super-ego, and they are not mutually exclusive phenomena.

Developmentally, conscience is there as a potential, but does not function autonomously until adolescence (Lukas, 2000). It remains intact in most cases. However, its ability may be limited by severe illness, senility, or immaturity (Lukas, 2000).

Our freedom and responsibility in each case extends to the point of responding to that which our conscience intuitively points out as meaningful, which, in turn our minds can perceive, and our "bodies" evidence and realise (Lukas, 2000).

9. The Resources of the Human Spirit:

According to Frankl, the human spirit is a "**medicine chest**" (Fabry, 1994; P. 18) of logotherapy, in that from the human spirit flows forth the *Will to Meaning*, manifesting itself in the *Defiant Power of the Human Spirit*.

Other resources of the human spirit include: **Conscience** (beyond the superego); **Creativity**; **Love** (beyond the physical), **sense of humour**, **capacity for choice** (beyond the instinctual), **commitment to tasks**, **ideas**, **ideals**, **imagination**, **responsibility** and **response-ability**, capacity for **self-awareness**, **self-distancing**, **self-transcendence**, **self-development**, **compassion**, **forgiveness**, and our **awareness of time, finiteness, fallibility, and mortality** (Frankl, 1994; Fabry, 1994, p. 19; Barnes, 1995c, p. 16; Guttmann, 1996, p. 25).

10. The Spiritual Unconscious

Earlier, we spoke about Frankl's *Dimensional Ontology*. We noted the way in which Frankl drew a parallel between the body and psyche as closed systems, and a contrast to the spirit, which is an open system, oriented toward meanings and the future.

Contrary to this marked boundary between spirit, and a psycho-somatic plane, Frankl (1975) theorised a basically fluid line between the conscious, pre-conscious, and the unconscious aspects of our existence in body, mind, and spirit (Fabry, 1994; p. 80).

Thus, Frankl (1975) extended the limits of the unconscious, beyond the psychological unconscious, to include the dimension of the spirit.

He noted that the depth and in its height, the human spirit in its essence is unconscious spirit, in that we can not reflect on its contents:

> "To sum up, spiritual phenomena may be unconscious or conscious; the spiritual basis of human existence, however, is ultimately unconscious. Thus the centre of the human person in his very depth is unconscious. In its origin the human spirit is unconscious spirit" (Frankl., 1975; p. 31).

Moral conscience, **aesthetic conscience**, and **intuitive conscience** (Frankl, 1979; p. 79) are three functions found within the realm of unconscious spirituality which help us discern and make a decision about how we respond to the voice of the transcendent, and to "truth," "beauty," and "goodness" which we intuitively perceive in it.

Frankl said that "*Logos is deeper than logic*" (Frankl, 1984b; p. 66)—human behaviour follows not always logical reasons, but existential decisions, which go beyond reason.

Our self-reflection has boundaries, and so does the ability to analyse oneself, has boundaries, in that existence in its depths and heights can not be analysed, they can only be analysed toward something, or someone, thus, they can only be lived (Frankl, 1975).

Complementing other treatment approaches, the task of the logo-therapists is to bring to conscious awareness that which only exists in the unconscious level, including what is in the spiritual unconscious—"…only in order to be able to allow it to sink back into the unconscious" (Frankl, 1975; p. 38).

> "To put it in the terms of the Scholastics, what therapy has to achieve is to convert an unconscious **potential** into a conscious **action**, but to do so for no other reason than to restore it eventually as an unconscious **habit***"* (Frankl, 1975; 38).

APPLICATIONS:

1. Individualizing Treatment:

In her memoirs on learning about the use of logotherapy as the student of Viktor Frankl, Dr. Lukas (1995) recalls how Frankl used to teach his students that there are at least two factors which they should consider in choosing the appropriate therapeutic method in the treatment of their clients: their own personality, and the personality of their clients. The chosen technique "Q" depends on the variable of what therapists are trained-, and ready to use, and believe in; "X", and what their patients are looking for "Y." ("Q= X + Y"; Fabry, & Lukas, 1995; p. 33).

Dr. Lukas soon noticed that if she wanted to respect her patient's individuality, their unique situations, and wanted to be helpful as a therapist, then, instead of remembering and following special formulas, she had to **listen** to her patients: "*I opened my ears to the simple expressions of my patients, I sought out the melody of their voices, and searched for the traces of meaning in their souls*." (Fabry, & Lukas, 1995; p. 33).

2. 2. Following Therapeutic Principles:

Notwithstanding, Dr. Lukas explains what is meant by improvisation and individualisation in logotherapy, as well as what are some helpful principles to guide the general approach to therapy with some personality structures that can be challenging to therapists, such as the (1) "The Insecure;" (2) "The Arrogant;" (3) "The Pessimist;" (4) "The Flighty;" (5) "The Depressed;" (6) "The Aggressive;" (7) "The Authority-dependent;" (8) "The Intellectuals;" (9) "The Dependent;" and (10) "The Lethargic" Personality Structures.

3. Combining Logotherapy with Other Forms of Intervention to Achieve a Variety of Possible Applications, and Increase Effectiveness:

A preliminary review of logotherapeutic literature, books, and journals, such as the International Forum of Logotherapy indicates that logotherapy has been extensively used in combination with other therapeutic methods in the treatment of chronic illness, addictions, severe mental illnesses, designing programs for individuals with mental retardation, handicaps, and in response to traumas, and emotional distress. The examples abound beyond our ability to list them all. However, a few selected articles from the IFL include Abrami (2001); Berti, & Schneider-Berti (1994); Boschemeyer (1982); Giovinco, & McDougald (1994); Haines (1986); Harris-Pergam (1989); Henrion (1987, 2002); Hooper, et al. (1996); Hutchinson (2002); Hutzell (1984); Hutzell, et al. (1991); Kass (1996, 1996b); Khatami (1987); Kimble, & Ellor (1989); Lazar (1984); Lantz (1984, 1998), Lantz, & Lantz (1994, 2001); Leslie (1982); Lynn (1981); Maniacek (1982); Olive (1990); Rogina (2002); Simms (1979); Starck (1981); Stavros (1991); Ungar (2002); Van Pelt (1994).

In all of these cases, a single most important factor guided and aided the Logo-therapist: patients' own will to discover meaning in their lives.

POINTS TO PONDER:

* Among the concepts that we discussed in this Chapter, which are the ones that fill you the most with a sense of "mystery?"

* Reflecting on the *Resources of the Human Spirit*, can you identify some of the concepts as definitely some of your own "treasures?"

* Along which dimensions would you list the "three virtues;" hope, faith, and love?

Chapter IV: Existential Dynamics and Existential Analysis

Logotherapy was specifically developed to respond to the existential search for meaning. This dynamics, "Meaning-seeking" becomes evident in the process of a careful listening to patients words, and exploring their reported experiences according to the principles of "existential analysis" (Frankl, 1994).

"Existential analysis" is not just a phenomenological summary of patients' present circumstances, their complaints, concerns, or feelings, but a discernment of their orientation to meaning.

The goal of existential analysis is to relate to the patients' world, and to accompany the patient in the search for meaningful responses.

Although the personal background is essential to understand the patient, existential analysis is not oriented primarily toward the past, or the here and now of the present, but to the future: to what capacities a person still has, or can have for realising meaning.

Existential Analysis is a form of dialogue which does not exclude discussing the patients' past and present, but its aim is always to involve the patient in a search for meaning in life with help from considering the resources and possibilities of the life-span.

An understanding of **existential dynamics** helps therapist gain an accurate picture of the patients' existential search in the process of **existential analysis**.

Below we present the key concepts of existential dynamics, according to Viktor Frankl's logotherapy:

1. Self-Distancing:

Intellectually, human beings have the capacity to anticipate the consequences of their actions. Insight, generally speaking, implies a possibility for self-observation, or introspection.

As we know that some conditions can be incapacitating, the extent to which we can have insight in certain situations requires the assessment of the mental health professional.

Beyond introspection, which is the observation of our own psychological or emotional state, we have a capacity to "step out" of ourselves and to observe our own selves. In other words, to put a distance between us, and our circumstances, and to observe ourselves, at times, with a sense of courage, gratitude, or humour (Lukas, 1998; p. 56).

This ability, which is a resource of the human spirit, is called self-distancing.

Self-distancing is relevant for being able to reach beyond ourselves to find meaning.

2. Self-transcendence

Self-transcendence is manifested in the human spirit's ability to reach beyond the present realities of the self, to what can be, and towards what "ought to be" (Lukas, 1998; p. 56).

The homeostasis principle, which underlies the dynamic interpretation of human beings, maintains that our behaviour is basically directed toward the gratification and satisfaction of our drives and instincts; the reconciliation of the different aspects of our psyche, such as id, ego, and superego; the adaptation and adjustment to society; and our own bio-psycho-and social equilibrium (Frankl, 1984b; p. 49).

In contrast, according to Frankl, our existence can not consist of self-actualisation, for our primary concern does not lie in the actualisation of our own self, but, rather, in the realisation of values and in the fulfilment of meaning-potentials which are to be found in the world rather than within the psyche, which is a closed system (Frankl, 1984b).

Frankl (1975) maintained that in order to actualise meanings, we constantly have to reach beyond ourselves. This reaching-beyond-oneself is the essence of the human potential called self-transcendence (Frankl, 1984b; p. 61).

Self-transcendence toward values is characterised by reflecting away from the self, forgetting about oneself, which, paradoxically, results in finding oneself in the process of actualising the intended value (Lukas, 1989; p. 56).

2. Noo-dynamics:

Frankl (1984b; 1996) affirmed, that in the dimension of our spirit, what we need is not homeostasis, but what he called "Noo-dynamics" ["Noos" is a Greek word, as is used to denote Spirit; Russell, 1996; p. 294].

Our main motivation in life is to search for meaning. That is our Noetic Dimension [Noos] needs Meaning [Logos]; (Barnes, 1995b).

Noodynamics creates a constant tension between who we are as human beings, and who we can be, if we accomplish a goal or follow an ideal. It is that kind of appropriate tension that holds us steadily oriented toward concrete values to be actualised, toward the meaning of our personal existence to be fulfilled:

> "What I call noodynamics is a field of tension whose poles are represented by us, and the meanings that beckon us. Noodynamics structures our life like iron filings in a magnetic field. In contrast to psychodynamics, noodynamics leaves us freedom to choose between fulfilling or declining that meaning that awaits us" (Frankl, 1975; p. 88).

Frankl (1996; p. 225) termed this tension "*...a tension between existence and essence, or being and meaning*." Meaning, he said "*…must always be one step ahead of being—only then can meaning fulfil its own meaning, namely to be a pacemaker of Being* (Frankl, 1972; p. 15).

In order to compare and to contrast homeostasis with noo-dynamics, Frankl (via Barnes, 1995; p. 22) poses this question:

> "We speak of the will to find meaning. Could we also speak of the drive to find meaning? The answer is no: a drive is for ourselves; will is for others. The aim of a drive is its own destruction. For example, if one is hungry, there is a drive to eat. After eating, the drive is diminished. The aim of a drive always returns self. In the will to find meaning, the meaning is the end of our intention… (Barnes, 1995; p. 22).

3. Existential Distress:

According to Frankl, whereas in the times of Freud one could speak of sexual frustrations, today's society is rather characterised by "*existential frustration*." And, as in the theory of Adler, one could speak of "inferiority complexes," logotherapy addresses feelings of "futility" (Frankl, 1984b).

Reflecting on today's society, Frankl (1984b) remarked that our times, are, on the one hand, characterised by a crumbling and loss of traditions, without healthy directions for young people, in which case, they may follow what the majority is doing, which leads to conformism. On the other hand, there are totalitarian systems which impose meaning and values and do not allow for a personal search for meaning.

In both cases, the lack of recognition of the relevance of the *Will to Meaning* in people's lives can lead to Existential Frustration (Frankl, 1984b; 1994).

4. Existential Frustration:

Existential frustration is a nagging feeling, which results from the frustrations of the Will to Meaning. It is not the sign of a disease, but rather of our humanity, as it alerts us to the relevance of a sense of meaning in life (Frankl, 1984b).

A frustrated will to meaning can be the result of lack of directions, the loss of traditional roles, or values, a conflict of values, or a substitution of what is truly meaningful with what is thought to bring happiness or pleasure (Frankl, 1967; 1984).

In any of these cases, when the Will to Meaning is substituted with a Will to Pleasure, or a Will to Power, or success, the result is self defeating (Frankl, 1984b). With a metaphor, it is as if a native hunter in Australia threw away his boomerang, and missing its target, the boomerang returned to the hunter (Frankl, 1984).

5. Existential Vacuum:

A long-standing frustration of the Will to Meaning can lead to the repression of the Will to Meaning. This condition is called existential vacuum (Frankl, 1967; 1984; 1984b, 1992), which is characterised by a sense of lack of meaninglessness and purposefulness. Its main symptoms are a feeling of emptiness and boredom (Frankl, 1984b; p. 122).

Frankl (1967) noted that the feeling of inner emptiness is especially widespread among the youth. According to an observation by Viktor Frankl, *twenty five percent* of his students in Europe, and *sixty percent* of his students in America confessed to it (Frankl, 1984; p. 111). Reportedly, the symptoms of meaninglessness and emptiness are also widespread symptoms brought to the attention of doctors in outpatient clinics (Frankl, 1984b).

The danger of the existential vacuum lies in the attempts to fill it with activities which further create distress by suppressing the will to meaning, such as pleasure, or success-oriented activities, such as "workaholism," defiance to authority, the hoarding of material goods, drug use, excessive behaviours, etc.

These futile efforts to fill the existential vacuum can lead to depression, addiction, or aggression, which Frankl termed as the "mass neurotic triad" (Frankl, 1984b, pp. 28-30). Furthermore, they can lead to emotional and mental disorders (Frankl, 1984b; Lukas, 1998).

On the other hand, the existential vacuum *is not a disease*, and a frustrated, or repressed Will to Meaning, can be brought to conscious awareness, which may trigger the search for meaning (Frankl, 1965, 1984; p. 74; 1996).

Frankl (1994) emphasized, that in this regard, the task of the therapist is to assure their clients that their feeling of emptiness is not a sign of mental illness but rather a challenge to fill this emptiness—a challenge to which only human beings can rise: "Only humans can feel the lack of meaning because only they are aware of meaning" (Fabry, 1994; p. 31).

6. Noogenic Neurosis:

Doubting the meaning of life may lead to a type of neurosis, for which Frankl coined the term "noogenic" neurosis (Frankl, 1965, p. 18; 1967, p. 81; 1994, p. 115).

Noogenic neurosis does not originate from the psyche. That is, it does not originate from the past, and is not brought on by repressed sexuality, childhood traumas, conflicts between different drives, or conflicts between the id, ego, and super-ego.

Rather, noogenic neuroses originate in the present. They stem from the dimension of the spirit is, and are brought on by value collisions, conflicts of conscience, or by not finding and perceiving an ultimate meaning in life (Frankl, 1984b; p. 81).

The major symptoms of noogenic neuroses are despondency, despair, and depression (Frankl, 1965; p. 18; 1994; p. 115).

These symptoms, in their manifestation, are very similar to that of other depressive conditions. Alternatively, noogenic neurosis may be superimposed on, or mask endogenous types of depression. Therefore, the diagnosis of noogenic neurosis always requires a careful diagnostic assessment.

The human spirit in the case of noogenic neurosis is not ill. Rather, the suffering in the dimension of the spirit brings about psychological symptoms, which can also go hand in hand with physical complaints. The main symptom of neurosis is anxiety (Barnes, 1995).

Crumbaugh and Maholick (1969) developed the *Purpose in Life Test*, and the *Seeking of Noetic Goals Tests* (Crumabugh, 1977) for the measuring of the degree to which one was able to find meaning. These researchers, who studied the manifestations of noogenic neurosis noted, that, unlike other forms of neuroses, noogenic neuroses does not respond to classical psychoanalytic treatment.

The symptoms of noogenic neurosis are best alleviated with a treatment that draws attention to the person's present and future—and helps the person gain resources for commitments to fulfil, relationships to establish, and to live life to the full.

APPLICATIONS:

Understanding the principles which underlie existential analysis is vital for accurate diagnosis, which not only considers suffering along the dimension of the body or psyche, but complements these with an understanding of suffering out of a frustrated will to meaning.

A careful diagnosis will lead to a careful formulation of treatment, which may include other treatment modalities (i.e. pharmaco-therapy with logotherapy, as needed).

In one of the first editions of the *International Forum for Logotherapy*, Frankl published two case examples. The examples were submitted by his students on the application of logotherapy in their own lives. [Frankl, V. E. (1979). Case Histories. The IFL, 2(2), 38-40].

> The first example (Frankl, 1967; p. 38-39) details the experiences of a young man, who suffered from endogenous depression, a form of clinical depression which has a genetic and biological causation, and where the imbalance of neurotransmitters in the brain produced a symptomatology typical of such illness, as its description as Major Depression can be found in the Diagnostic and Statistical manual of Mental Disorders (DSM IV-R).
>
> Among other symptoms, this type of depression manifests itself in lack of energy, and motivation, intensified feelings of guilt and worthlessness, affective lability, irritability or lethargy, loss of appetite, or weight gain, sleeplessness or hypersomnia, difficulty making decisions, lack of concentration, suicidal feelings, etc.
>
> The young man consulted several therapists, who did not recognise the true origin of his illness, and who attempted to treat it with psycho-therapy. The psycho-therapy that he received was unhelpful and even worsened his condition.
>
> It was not until he attended Frankl's classes that it became clear to him that this illness had physical causes, and psychological manifestations. Only the appropriate pharmaco-therapy, combined with psychotherapy, and logotherapy, could free his, otherwise healthy spirit, from the bondage of these symptoms.
>
> The second case example (Frankl, 1979; p. 39-40) is that of noogenic neurosis, experienced by a young therapist, who was caught in a conflict with his own conscience about to what extent to follow it, and how to behave during his supervision meetings when he did not agree with his supervisor.

> Since he received classic psycho-dynamic training, he and his friends attempted to alleviate his condition, which was marked mostly by an immobilising fear, and distress, threatening to lead to more severe forms of mental disturbance.
>
> To his dismay, his symptoms of anxiety and distress worsened, until the point when he realised that his own "self-suppression" was causing and maintaining his problems.
>
> He was able to stop his therapy, and make a decision to start to express his opinions in the supervision sessions. He was no longer afraid of losing his job as his peace of mind became more important to him than his job. As he kept expressing his opinions, his anxiety improved, and after two weeks, it disappeared completely.

POINTS TO PONDER:

* According to Lukas (1989; p. 50), in meaning fulfilment, two complimentary parts come upon each other. An 'internal' part, the striving and longing for meaning, and an 'external' part, the meaning offered by a situation." If the will to meaning is restricted through illness, immaturity, or senility, which could be the case, then it is about an impairment of perception of the '*external part*' and less about the restriction of the '*internal*' part. The 'internal part' (the Will to Meaning) remains an identity of humanness even in the case of serious illnesses.

Reflecting on the above two case examples, identify ways in which logotherapy focuses on positives, and on what is right with the patient, instead of what is wrong.

VOLUME II—LOGOTHERAPY

Chapter V – The General Process of Logotherapy

To understand the general process of logotherapy, we need not only to know the basic principles of **Logo-philosophy**, but also to learn about the methods and techniques of **Logo-therapy**, which can be employed at certain stages of the therapeutic intervention.

This learning is not dissimilar to that which takes place in departments of psychology, and counselling, psychiatry, nursing, or social work, where students are first exposed to theory, to later practice the applications of the theory in real life.

In the following chapters, we will focus more intensely on the application of those principles which we described earlier in Volume I. We will incorporate them into a framework that will allow us to gain a glimpse of what the good practice of logotherapy looks like.

While this can be most effectively done in real life, and with real examples, we will gather the best recoded evidence we found in literature that will allow us, at least to have a good theoretical knowledge of how logotherapy is applied.

The description will be helped by the practical teaching and experience of many logotherapists, among them Dr. Elisabeth Lukas, who for many years, offered an intensive, two week seminar and workshop on the applications of logotherapy, entitled "*The Dialogue Forms in Logotherapy*," which acquainted participants with her skills, and gave a first-hand experience, rarely available from books.

According to Dr. Lukas (2000), the first key principles which guide every therapy intervention are knowledge, and wisdom, but also the willingness to **individualise**, **improvise**, and to consider every person, different from everybody else, unique, and special, with a potential to realize that meaning which is uniquely given to them.

We can picture the logotherapeutic treatment is that **process**, whereby meaning is discovered, and clarified, to the point that patients recognise them as their own, and something that they own and are in a unique and irreplaceable position to accomplish.

There are many forms in which logotherapy can be applied, such as with:

* **Individuals**, across the life-span: (i.e.; Boschemeyer, 1982; Eisenberg, 1996; Ernzen, 1997; Hirsch, & Kalmar, 1982; Kalmar, 1982; Leslie, 1982; Lukas, 1986; McLafferty, Jr., 2003; Mori, 1991; Pintos, 1993; Rice, 2000; Rife, 1990; Schulenberg, 2002; Stefanics, 1996; Welter, 1994; Yoder, 1983);

* **Couples**: (i.e., Lantz, 1984; 1987; 2000; Lantz, & First, 1987; Lantz, & Harper, 1991; Lantz, & Lantz, 1994);

* **Groups:** (i.e., Berens, 2003; Berti, & Schneider-Berti, Lantz, 1984b;1993; 1996; Lazar, 1984; Eisenberg, 1979; Crumbaugh, 1988; Martinez Romero, 1988, Pergam, 1989; Sibaja-Makai, 1979; Lieban-Kalmar, 1979; Whiddon, 1983);

* **Organisations:** (i.e., Dansart, 1993; Estes, & Welter, 1994; Hirsch, 1994; Lukas, 1985; Starck, 1985; Starck, 2003; Wintz, 1997; Wright, 1996);

* **Society**, **and Across Cultures**: (i.e., Asagba, 1996; 1994; Byung-Hak Ko, 1981; Frankl, 1984; Jilek, & Jilek-Aall, 1986; Kanahara, 2003;; Millul, 2003; Rahman, 2001; Salthouse, 2003; Stecker, 1981; Stecker, 1985; Troyer, 1986).

Underlying the applications of logotherapy in **varied modalities**, and with **various problem categories**, is a process of **dialogue**, an encounter, which is key to the intervention, and flows between its phases and stages. It can be seen during (1) The "**Initial Dialogue**;" (2) The "**Middle Dialogue**;" the (3) "**Closing Dialogue**;" and (4) "**Follow-up Dialogue**" (Lukas, 2000).

The process of logotherapy can be further broken down to its smaller elements of specific treatment phases, stages, techniques, methods, or dialogue forms, which we will mention in subsequent sections. As we will see, all of these smaller elements bridge and connect the larger building blocks of the treatment intervention, and organise them into a whole.

Very aptly, according to Frankl, the task of the logotherapist similar to the optometrist: to help us to see clearly. Or, to put the metaphor more concretely, to sharpen our spiritual "vision" to discern the meaning of our lives.

Subsequently, as we proceed to examine the elements of the logotherapeutic intervention, our aim will be to present a comprehensive and accurate picture of how logotherapy is practiced, and how its smaller elements fit into the context of the whole. We will begin this study with a look at the elements of the meaning-oriented intervention:

1. <u>The Initial Dialogue</u>:

The *Initial Dialogue* usually starts with "**Anamnesis**"—the recording of the history, and the antecedents of the presented concerns, and the context in which they arose. They are aimed at understanding the person's physical, emotional, social, cultural, and spiritual background, present circumstances, and aspirations.

Most therapists, especially those who are trained in the medical model, tend to ask structured questions. While it is unavoidable and necessary to cover a broad context, not all questions need to be asked during this stage (Lukas, 2000). Its purpose is only to give an initial understanding for the patient to the therapist, and the therapist to the patient, and to build a therapeutic alliance, and rapport; to acquaint with each other, and to build a foundation for the meaning-oriented therapist-patient relationship.

Dr. Lukas noted that the goal of the *Initial Dialogue* is to narrow down the communication to a **specific content**, and to establish a main topic or **theme** that will be discussed later. For this, it is often necessary not only to allow patients sufficient time to think, and express themselves, but to **limit** the conversation, and to **put boundaries**—so to speak, **steer** the conversation.

The goal of the therapist is to strive for an honest and real understanding of the **personal points** that patients raise. For this end, it is sometimes needed that they clarify the content, and to summarize their understanding, by saying: "*I understand that…*" or, "*I do not understand this quite well….*," until a common, shared understanding is reached, about what will need to be understood, perhaps in a different light, later.

Thus, the first goal is not to interpret, or to change the perception, but to understand patients in their reality.

For this, one has to allow enough time for patients to talk, and to express themselves about their values and meaning. Sometimes it is relevant to question, which shows that the therapist takes the patient seriously.

The therapist's main task is to **listen**: Everything is interesting in the conversation that alludes to resources, expectations, relationships, and strengths. One can draw special attention to these facts from the dialogue right away.

It is relevant not only to register the complaints, but to notice what patients can do, and what they can do well; what are their interests. Also, therapists can notice and point out what appears from the conversation as nice, beautiful, healthy, and hopeful.

Therapists should avoid to moralise, or to ask questions in a way that shows a prejudice, or a condemnation of patients' previous actions, or circumstances.

Therapists need to communicate **honestly**, and to say only what they are also convinced of from their practice, or from their own life experience, what they honestly and truly believe in. Patients are very sensitive to the therapist's reactions, and they can detect very well if he or she is deceitful, or if she or she does not really believe in what she or she says, and than they do not take the therapist seriously.

During the dialogue one can ask for expectations: the advantages, and disadvantages of what is reported. Inquire "*Is what you say really so?" "Do I understand you well?"* Ask open ended, future-oriented questions: *"What do you estimate the chances are that this can be changed*?" (Lukas, 2000).

It is necessary to pay attention to the patient's inner attitudes, to their feelings. For example, hate, lack of gratitude, lack of forgiveness, neurotic self-observation. The goal of therapy will be later to instil hope, help forgiveness, and to foster a sense of gratitude, but this takes some time to achieve.

By the end of the first dialogue, the goal is to register what is healthy in a person, along with his or her problems; what can not be taken away from a person; what still may be possible to do, and to communicate **empathy**.

Lukas (2000), and Harris (2001) noted that the role of language is crucial, because, just as patients language communicates to us, the language the therapists use communicates back to the patients. It is relevant to use language to communicate grace and dignity, and to present a picture that is healthy, rather than burden patients even further, or just reinforce their previously held painful thoughts, or unhelpful beliefs.

In a few points, the major tasks of the Initial Dialogue are as follows:

(a) Provide a ground-structure;
(b) Be aware that even unnoticed, first impressions, and examples live further;
(c) Orient the dialogue in an empathetic way to areas where there is hope that something can be done;
(d) Exemplify a dignified approach where one has to remain patient;

2. The Middle Dialogue:

The *Middle Dialogue* usually starts with the intervention. However, this stage must not be identical with what patients think is the actual intervention. In other words, even before the application of certain methods, exercises, or suggestions occurs, the dialogue already prepares patients for something more to come.

At this stage therapists listen to "**key words**," and once they have identified a topic with the patient, which will be further elaborated on, they can ask for possibilities: *"What would happen if..."* (Lukas, 2000).

In the beginning of the *Middle Dialogue*, or the therapeutic dialogue, it is not uncommon to offer small suggestions to start with, just as "first aid." This will help to put out the "initial fires," and put patients mind at ease and prepare them to handle the remaining tasks.

However, once a main topic is started, one has to stay with it: Identify certain aspects of it, points about it, and pay attention to patients' body language. Underline certain phrases, key concepts, words, and statements, and repeat parts of the dialogue which suggest the way further.

If there is resistance, therapists have to look for other points, and start from another direction.

Dr. Lukas remarked that it is in general better to stay a few points initially, than to say too much, and to overwhelm patients. However, the therapy process from then on has to be a systematic, and thorough, point-by-point dialogue.

For example, in the case of **forgiveness** as a topic, one has to take a look at both sides; take a look at facts from perspectives, take a look at the good and bad sides of the persons involved, and the decisions made. Realize that just as others have their good and bad sides, we too, have made mistakes.

If we take the first steps toward reconciliation, the achievement will be ours. However, we have to endure the pain of honestly evaluating ourselves, and noticing our own strengths, and shortcomings.

Just as we evaluate our own "guilt" and "merit," so we can proceed to name the guilt and merit of the others involved.

Usually, as in the case of seeking reconciliation, we start with defences, and what is called "cognitive dissonance:" We have thought about a problem in a certain way, and we have amounting evidence for the way and reasons why we held our beliefs this far; until evidence starts to mount for another way of looking at the same event.

Sooner, or later, the dialogue comes to a "**turning-point**" (Lukas, 2000). This is at the time, when one is ready to decide to use the further information for making a new decision.

In the presented case, for example, it may come after considering the positive and negative actions of the other, and their strengths and weaknesses, and noticing that "*no one is really a devil incarnate*"—which is a key phrase, and signifies an attitudinal, inner turning point.

After this, one is able to repeat the main points about the findings and evaluation of the situation, summarise what was established, and reaffirm the readiness to seek new ways of looking at what happened: the past of the person can be considered; the circumstances surrounding the event; etc. The dialogue may proceed with a realisation that "*we are not the others' final judge*;" but we can choose how we want to react to what happened, for our own sake. Future possibilities and action plans can be drawn up, and evaluated in terms of their desired outcome. Also, if the patient considers them possible to accomplish, and can prioritise them according to their personal sense of meaningfulness.

The dialogue may continue in the direction of employing specific logotherapeutic techniques (such as **Paradoxical Intention**, **De-reflection**, **Modification of Attitudes**), or the clarification of what is meaningful in the context of **Narrative Logotherapy** (using the Socratic Dialogue, Careful Differentiation, the use of Stories, Symbols, and Metaphors; Lukas, 2000; Moore, 2002), which we will describe in the subsequent chapters in more detail.

Relevant about the *Middle Dialogue*, or Therapeutic Dialogue, is to know that there are always **two sides** to a person or the problem which is presented. There is already an **inner dialogue** within the person with him-, or herself, about what is a senseless, and what is a more meaningful way of approaching problems. The art in therapy is to capture this dialogue, and to see where it got 'stuck' where there is a dissonance, which perhaps can be helped, so that people can help themselves further. This is "**sore-point**" is captured, and fleshed out by the key word, or the key formulation.

For example, if someone wishes to grow, but he or she is very uncertain about the direction to take, we can ask: *"What would you say to a child in this situation?"* By contrasting the child and the adult, we make a hypothetical inductive-deductive link with the present "wishing-to-grow-self" and the future "mature-self:"

It is less frightening to talk to a little child from the maturity of the adult, then the other way around, which can lead to the advice: *"Be wise with yourself just as you would be with a child"* (Lukas, 2000).

As we will see, logotherapy's methods frequently make use of **contrasts**, or **paradoxes**, to discern what is meaningful. For example, throughout their dialogues, and techniques logotherapists make use of the **span** between what is and what can be; between what is impossible and what can still be achieved; and between what is healthy and what is ill.

Dr. Lukas advised to explore both sides of options, and possibilities to arrive to that which one intuitively will judge to be more meaningful. As a general rule for this decision, she noted that meaningful can be only that decision, which is beneficial for all who are affected by it.

In deciding value conflicts, or what direction to take, one's conscience will show the path, but it is important to give voice to one's **inner dialogue**, which can be done only in the context of a caring and trusting patient and therapist relationship. The purpose of the dialogue is to name possibilities, and to identify which result in most benefit to all involved. This in turn, restores confidence in oneself to find meaning in a similar way in other situations.

Another key point that Dr. Lukas emphasized is that comparisons are best made with one's **own self**: *"Compare yourself only with your own self; how much strength and potentials you already have"* (you in your unique situation, unlike anyone else).

Facing morally or ethically questionable decisions is not easy for therapists. In this case, Dr. Lukas advises not to challenge patients' questionable decision directly, unless it is a point that requires immediate attention, (e.g., suicidal thoughts, in which case the therapist is ethically required to state his or her own convictions, and act accordingly). In all other instances, where there is time to think over, one can draw attention to strengths, and unique talents, and appeal to the patient's sense of judgement, for which in their freedom of thought, they carry responsibility.

In the case of **anxiety neuroses**, Dr. Lukas advises they may be related to unhealthy attitudes, which have to be discovered first (such as egocentricity). If there are unexplained somatic complaints involved, one can suggest to "*leave these on the side*" for a while. One can use autogenic training, guided imagery, and relaxation exercises first. Then, come back to the physical symptoms alone, and suggest trying paradoxical intention. For example, in a humorous way, demand from oneself to have a heart attack, exaggerate symptoms, which will result in the attitudinal change: *"I do not have to take every non-sense from myself so seriously.*" This will result in a reduction of the original symptoms.

In the case of a lot of **anger** and **hostility**, Dr. Lukas advises to find out in the conversation the underlying motive. First, talk about all those who were present, the facts, and then to highlight the possibility to decide for oneself what one wants in the future.

If there is no readiness to evaluate this at the present, or there is something else more important, one can say: *"We leave this block here for a while, and we will come back to it another time."* To continue the dialogue, one may say: *"Can you imagine that one day we can talk about your future without necessarily talking about this person, or event, that caused you so much upset?"*

3. The Closing Dialogue:

The purpose of the *Closing Dialogue* is to review the goals, and to summarize the accomplishments in the therapy, preparing patients to return to their environment with less support from the therapist. By this time they have already reached some success in dealing with their problems, and they experience a reduction in their symptoms. They report themselves ready to reduce the number of meetings, or to prepare for stopping to come altogether.

Key points are repeated, usually key metaphors, or stories are shared, and patients anticipate that they will function better than previously.

Therapists offer to stand by if there will be a need to come back, in which case, they can refresh what was discussed previously, or brainstorm another tactic if something has come up that patients were not prepared for, and caused them suffering beyond what they could handle on their own.

The task of the *Closing Dialogue* is also to recognise patients' strengths, and to allow them also to express their view on the process to the therapist. They are now ready to act independently, and responsibly, and this shows in their confidence in themselves and readiness to say good bye to the therapist.

4. The Follow-up Dialogue:

The *Follow-up Dialogue* takes place if patients want to return after some time to tell the therapist how they are doing, or if they need some minor advice, or reassurance, and encouragement. Its role is very vital in that the knowledge that the therapist is still available makes patients feel stronger. Subsequent dialogues can refresh the previously discussed points, and increase patients' resilience.

There is no need to worry that patients have forgotten what was discussed.

Sometimes patients will recall the exact words that the therapist "said to them." Usually, however, what stays with them, rather than direct words, are salient images, key phrases, or a general impression, as the spoken words resonate in their own world-view and dialogue with themselves, and found its home in a dialogue with their own conscience. In this case, the therapist can contently step back.

SUMMARY:

Above, we summarized the general process of logotherapy in the form of a meaning-oriented therapeutic encounter. As we proceed, we will continue to take an analytical look at this process. First, we will highlight the phases of the therapeutic process (Diagnostic Phase; Therapy Phase; and Follow-up), followed by a look at the specific techniques (Paradoxical Intention, De-Reflection, Modification of Attitudes, etc.), and principles that govern the therapeutic dialogue (Narrative Logotherapy).

POINTS TO PONDER:

* According to an anecdote, Michelangelo, the famous artist was once asked how he managed to create the beautiful images which we see in his paintings and sculptures. "*I imagine the figure trapped inside the stone*" said the master, "*and I take my instruments and chisel until I am able to set it free*."

In a film about his life, there is a scene where Michelangelo is commissioned by the Pope to paint an image for the Sistine Chapel. He is desperately looking for inspiration: he goes out to the balcony, where he has a fabulous vision of the skies, with dramatic clouds moving across the horizon. Michelangelo takes the breathtaking scene as the inspiration for painting the "Creation of Adam."

In these examples, what reminds you of the "inductive and deductive process" that we encounter in dialogues? Do you ever have the experience of something "greater" behind the outer surface of the words? To what extent can we use words to express what is in our hearts?

Chapter VI: Logotherapeutic Intervention

(1) The Diagnostic Phase:

Logotherapeutic treatment goes beyond an analysis of the presented problems to see the background within which they exist. Even in the diagnostic phase, the therapist is aware that a thorough inventory has to be taken to understand the concerns.

Therapists also know that at the time when patients come to the office, they have been preoccupied with their fears and recalling what they will share with the therapist, just as the therapist is also bound to think about what questions have to be asked first, and what information has to be solicited.

Patients' anxious self-observation already leads to hyper-reflection on their problems at the start of therapy. If the therapist is not careful, this hyper-reflection can be increased by asking questions that focus on deficits, and focus on problems alone.

What can happen in the case of hyper-reflection is a cycle that the therapist contributes to during the therapy, which constitutes of a strengthened negative view of the self and one's abilities, or capacities, and an overestimation of the negatives, to which the therapist has to find a "cure."

The problem can be that if this already existing cycle is not broken down right from the start, then it becomes stronger during therapy, and in this case, the therapist has to increasingly struggle to "undo" some of the hyper-reflection that was introduced in the beginning of therapy. If this task fails, the danger of relapse at the end of therapy is high, as evidenced during the follow-up, when questions about the initial problem immediately elicit an anxious rumination about it, instead of what one hopes for a healthy outcome otherwise, which is a reflection on current, meaningful activities, and "forgetting" about the previous problem.

A case example could illustrate this point:

> A young man is complaining about his inability to decide what course of action to take, and reports that he recently resigned from university classes. He reports that he had an argument with his father, during which words were exchanged, and it seemed to him that his father was not interested in helping him. The therapist then ask the young man what he did in response to his father's lack of interest. The young man says he withdrew to himself and decided not to talk to his father. He went into his room and was feeling angry and resentful towards his father the whole day.
>
> There could be many possible explanations for what happened, and at this point the therapist is very far from knowing how the young man can be helped. However, if the therapist was interested in the anger, and where it is coming from, he could ask the young man: "Tell me more about your father."
>
> Upon which the young man may say that he really dislikes his father, and he never had any good relationship with him, as his father was unsupportive for most of his time of growing up and distant form him.

In this very simplified example, if the therapist, at the end of the conversation, only summarised what the man said: "*You really don't get along with your father*," the statement already steered the topic in one direction which seems conclusive. The words do not imply change, do not imply temporality, and do not lead to exploration, or discovery.

Alternatively, a therapist, who operates solely from the perspective of the medical model, may focus on the young man's indecisiveness, low mood, and conflicts with his family. This therapist may interpret these complaints in terms of symptoms of depression, to which there seems to be evidence, upon which pharmaco-therapy may be indicated. If the student refuses to take the prescribed medication, the therapist may conclude that he "lacks insight" and is "not compliant with taking medication."

Even if the student's indecisiveness is coupled with low mood, conflicts, the symptoms do not have to be necessarily part of a clinical depression, especially not clinical depression which is endogenous in nature. To diagnose his condition as "depression" would perhaps cement the definition of depression on his personality beyond what is actually true. –"Depression" is a term which is already much too prevalent in our everyday language.

1. Avoiding Hyper-reflection:

Thus, the first task of the Diagnostic Phase is to **avoid hyper-reflection**.

Fortunately, in most cases, the initial interview is very open, and such conclusions can be easily avoided if the therapist keeps an open mind. For example, even after asking the young man about his father, and hearing about the incident that happened, the therapist may reflect: "So I understand that this past week it was hard to communicate with your father." "Are times when you find it easier to talk to him?"

And furthermore, "*In what ways do you see that consulting with your father could be relevant in relation to your decision to end your studies*?"

As we see, the counselling session has to start with questions that are open ended, and which foster exploration, instead of locking people's reported complaints into one pre-conceived notion.

Good questions are the ones which provoke reflection, and illustrate slight differences-- "shades"--and clarify meaning (Lukas, 1998).

Dr. Lukas (1986) explains further:

> "The basic concepts of logotherapy have helped me to see that hyper-reflection must be counteracted right from the start, even at the expense of information which can be produced later. This procedure presents a dilemma for counsellors because they need to get early diagnostic information and must ask certain questions and conduct certain inquiries, but this can be solved by a technique which I call "alternate diagnosis."
>
> The alternate diagnostic technique satisfies both requirement of the diagnostic phase: it allows gathering information without raising the client's level of hyper-reflection. In this technique the counsellor's interest alternates between gathering information and de-reflecting toward positive life contents (Lukas, 1986; p. 42).

The **Alternate Diagnostic Process** in the case of a woman suffering from insomnia may look like this:

> A. "Query about frequency of sleep disturbances. Talks about such subjects as day and night rhythms.
> B. Query about such activities which the client likes to do and to which she could turn in sleepless hours (reading, listening to music, solving a puzzle, cooking).
> C. Discussion of these activities and her experience with them.
> D. Query about connections between emotionally strenuous encounters and the occurrence of sleep disturbances.
> E. General dialogue about the client's encounters with relatives, friends, acquaintances.
> F. Discussion about possible links between some of these persons and the client's hobbies, inclinations, and interests.
>
> In this example, two questions (A and D) dealt with the client's symptoms, the other four were set up to counteract excessive attention to sleep problems, and to focus her interest on other, more healthy areas of life. Every question about sleeplessness might have increased hyper-reflection, but the other questions helped to lower it again, so that the client entered her second therapeutic phase at a level of hyper-reflection no higher than she had brought to the diagnostic phase in the first place" (Lukas, 1986; p. 42).

Dr. Lukas noted that this diagnostic process alone may, at times, help patients to see their difficulties in a new light, and more manageable: "Though rare, it indicates that this form of initial contact contains therapeutic elements not evident in regular diagnostic inquiry" (Lukas, 1986; p. 43).

2. <u>Avoiding Iatrogenic Damage</u>:

The second task of the therapist during the diagnostic phase is to **prevent iatrogenic damage**.

Iatrogenic damage is a term used to refer to harmful therapeutic intervention.

"Iatrogenic neurosis" (Lukas, 1986; p. 39) occurs in counselling psychology when therapists are careless about their remarks and behaviour, which, inadvertently, causes the patient's symptoms to intensify.

For example:

> "A neurologist told a woman suffering from a slight confusion that she had an 'attack of paranoia.' Her initial symptoms were completely cleared up by the medication that this doctor prescribed, but the fear of renewed attack of paranoia darkened her life years after the episode. A long period of anxiety, insecurity, and self-doubt undermined her self-confidence and prevented her from enjoying life. Although she never had a relapse, and it is not even certain that she actually had a genuine attack of paranoia, she now suffers from iatrogenic neurosis caused by a few words of the neurologist, who treated her correctly, freeing her medically form symptoms that had brought her to him (Lukas, 1986; p. 38).

On the other hand, it is the task of the diagnostic phase to illuminate psycho-somatic connections, somatic concerns, somato-psychological, and spiritual connections (Frankl, 1993; Lukas, 1986; Lukas, 1998; Ungar, 1999).

Causation and manifestation, ethiology and symptomatology, (Frankl, 1993), the Noo-psycho-somatic connections (Frankl, 1993; and Lukas, 1998), the presentation of the illness (patho-plasticity; Frankl, 1993), are very relevant to be understood.

The therapist listens, reflects, summarizes, and probes. And, already at this stage, the probes are aimed at clarifying **meaning**.

The task of the initial interview is to understand the patients' world, and to relate it to the therapists' mindset. However, beyond thinking in terms of diagnostic categories, which can be found in Frankl's *Theory of Neuroses* (1993); the diagnostic categories of the *International Diagnostic Code for Classification of Mental and Behavioural Disorders* (ICD-10; 1992) and the *Diagnostic and Statistical Manual of mental Disorders* (DSM IV, 1994), even in this initial stage, a rapport building takes place, which helps the therapist to *understand*, and helps the client to **de-reflect** from the problems alone, to what has been tried, what resources exist, etc.

In other words, during the diagnostic phase, a strict clinical interview schedule sometimes has to be interrupted to allow for personal explanation, and individualised questions. Only then can the therapist start to listen, not only to what the patient sees as wrong, but what they see as right, where they see an area of freedom, and where they see hope.

As we mentioned earlier, good questions and reflections are the ones that do not only help to see reality as it is, but span the past and the present, to finally, open up to the future, where a plan is formulated, and options still exist.

Dr. Lukas explained that iatrogenic neuroses can not be avoided by not making a diagnostic statement, or by not addressing issues which seem burdensome and troubling to clients. For the therapist's silence may provoke anxiety in patients who have been waiting anxiously to present their issues and to gain a professional perspective on it.

Alternatively, patients may interpret the therapist's silence as the sign that they have not been listened to, or understood, or, even, that something is "very wrong" with them. And yet, a "truthful" answer may also be damaging to patients who ask "*What is wrong me*?" (Lukas, 1986; p.39).

In order to prevent and to counteract iatrogenic neuroses, counselling psychologists may follow two guidelines: (1) "stick cautiously to the truth but present it within the framework of what is meaningful in this case, stressing the positive aspects" (Lukas, 1986; p. 39); and (2) "link the diagnosis to thoughts that prompt a smile in the client, as for those who can smile about their problems are on their way of overcoming them" (Lukas, 1986; p. 40).

When patients can express their problems in a supportive and compassionate environment, and when their concerns are presented to them in the same way, then, instead of explaining them away, dramatizing, or pathologizing, which result in fear, dependency, and hopelessness, patients can gain a healthy distance between themselves, and the "problem." In return, they gain confidence in the therapist, and in themselves.

In this regard, Dr. Lukas provides the following two case examples:

> Case 1: I once told an extremely frustrated and shy young woman that she was a pleasant exception to the prevalence of excessively self-centered people around, and that I wanted to help strengthen her assertiveness only to protect her in this egoistic world, and not to change her personality. This 'diagnosis' alone lifted her self-confidence and laid the foundation for further logotherapy. To diagnose her as suffering from a serious inferiority complex would not have helped. It might have helped *me* to develop a therapy plan against a problem which I had intensified" (Lukas, 1986; p. 39).

> Case 2: An elderly man asked me anxiously if his pattern of depressive phases would recur for the rest of his life. According to the result that I held in my hands, this was likely. I told him: 'No one can tell with certainty whether a depression will come back. But we know for certain that you have come out of your 'downs' every time and lived in long periods of 'ups.' You have so many healthy ups ahead of you that you had better start thinking soon about what you are going to do with all this healthy time.' The patient acknowledged the answer with a quiet smile although he well understood the truth" (Lukas, 1986; p. 40).

In conclusion, Dr. Lukas explains:

> "The truth is never clear cut, not in religion, not in physics, and not in psychology….In the human dimension, truth is always more than truth. It moves toward happiness or suffering, satisfaction, or despair. The success of therapy may depend on how the counsellor handles 'truth' in the diagnostic phase—presenting it in a form that enables the client to accept it with confidence" (Lukas, 1986. p. 40).

POINTS TO PONDER:

* Have you ever witnessed hyper-reflection, and iatrogenic damage? What could have been done differently in these situations?

(Role-play a possible scenario, and reflect on what the therapist and the patient report on their experience in these situations).

(2) The Therapy Phase:

The logotherapeutic treatment usually consists of four stages which were described by Lukas (1994; 1996):

1. De-Reflection:

Following the diagnostic stage, the first goal of the therapeutic phase is to help patients put a **distance** between themselves and their symptoms, or presented concerns (Lukas, 1996). They are helped to recognise that they are not identical with their fears, their past, their obsessions, low self-esteem, insecurities, inadequacies, depressions, addictions, physical illness, or emotional outbursts. They are encouraged to see that they are not helpless victims of their biological, psychological, and social circumstances; that they do not have to remain the way they are, and that they can take a stand toward their circumstances.

This phase is highly individualised, and it can be accomplished by (1) outlining what lies in one's area of **freedom** and **fate**; (2) outlining the **negatives** and the **positives**; (3) outlining what lies in the **past** and what may be possible to accomplish in the **future**; (4) outlining the area of **no-responsibility** and **responsibility**.

The *Logotherapy Textbook* (Lukas, 1998) elaborates extensively on the "**Dialectic of Susceptibility and Intactness***"* (pp. 25-29); the "**Dialectic of Pleasure and Meaning Orientation**" (pp. 30-37); and the "**Dialectic of Character and Personality**" (pp. 47-53), which helps therapists to incorporate their patients' experience in a meaning-oriented framework, which opens the door to self-exploration and growth.

Related literature can be found, for example, in Frankl's book (1986) "*The Doctor and the Soul*," in which, chapter after chapter, Frankl highlights these principles in the case of treating individuals suffering from Anxiety Disorders, Endogenous Depression, and Schizophrenia. In these examples, Frankl is careful to point out where clients' area of **freedom and responsibility** can be used constructively in treatment, when, for example, instead of ignoring, or downplaying, the therapist outlines the area that patients can not control, (i.e., their physiological reaction), and an area that is still free, (i.e. their cooperation with treatment, their attention to themselves, their undisputed self-worth), where, and through which patients' can aid the therapist in the treatment.

Fine case examples are also presented by Dr. Lukas in her book *Meaningful Living* (1984), and *Meaning in Suffering* (1986), and in the *International Forum for Logotherapy* articles, especially in the 25th Issue, presenting Treatment Protocols. In this issue, for example, my article (Ungar; 2002), presents an overview of the use of the "Dialectic of Freedom and Fate" in the treatment of endogenous depression.

As we see, the aim of this phase is to assist patients to see what they unconsciously already know, that *"...they are first and foremost human beings with a capacity to find meaning, and only secondarily, individuals with shortcomings, and certain unwanted patterns, which they can break*" (Fabry, 1994; p. 132; Ungar, 1996).

2. Modification of Attitudes:

The second step in therapy aims at **modifying patients' attitudes** (Lukas, 1996). Once they have gained distance from their symptoms, they are open to re-considering what values and attitudes they have toward themselves, others, and toward life, and if there are any attitudes which can be exchanged for a healthier attitude in the hope of leading a more fulfilling life.

In the book, "*Der Leidende Mensch*" (The Suffering Man; 1996, pp. 193-1944) Frankl outlined four types of unhealthy attitude-clusters which can lead to psychological disturbances: (1) **The Provisory Attitude**; (2) **The Fatalistic Attitude**; (3) **The Fanatic Attitude**; and (4) **The Collectivistic Attitude**.

1. Provisory Attitude: Apparent in lack of aims and plans for life, in making no efforts in reaching one's goals, and being directed solely by wishes and impulses. This attitude is manifested in indecisiveness, lack of goals, and commitment (Lukas, 1996). It leads to self-indulgence, bitterness about life, and hopelessness.

2. Fatalistic Attitude: Manifested in the assumption that everything is determined, and that everything can be explained. The fatalist person does not recognize higher dimensions unattainable to humans. He or she trusts in human potential, and puts all responsibility on human will and human ability. This thinking does not leave space for mystery, or compassion. It is manifested by a cynical and pessimistic outlook on life, with difficulty empathizing with others, irresponsibility, inactivity, seeking control, and superstitious beliefs.

3. Fanatic Attitude: Can be seen in a tendency to elevate a relative value to the absolute level. In the thinking of the fanatic person, this elevated value becomes idealised. Lukas (1996) warned that fanaticism foreshadows an emotional crisis each time a selected value is lost; it can not be attained, or it is attained only temporarily, because in the "pyramidal" value system of the fanatic person, there is no broad value-base that can replace the ideal value.

4. Collectivistic Attitude: Can be observed in following the opinion of the majority to the extent of abrogating one's own individuality and personal responsibility (Lukas, 1996).

In addition to the above described, so called "**Collective Neurotic Patterns**" Frankl (1993), and Lukas (2000) identified four "**Individual Neurotic Patterns**,"
which "radical" attitudes lead to emotional suffering, and feeling alienated from oneself, and society: (1)"**Wrong Passivity**," leading to "Excessive Avoidance;" (2) "**Wrong Activity**," leading to "Excessive Fighting Against Something;" (3) "**Excessive Forcing**," leading to "Hyper-Intention;" and (4) "**Excessive Attention**," leading to "Hyper-Reflection on the Self."

1. Wrong Passivity, Leading to Excessive Avoidance:

   In general practice, we see this vicious cycle in the case of **excessive fearful reactions**, **panic attacks** (DSMIV, 1994; p. 394), **phobias** (DSMIV, 1994; pp. 405-411), **avoidance behaviours**, and low self-esteem.

   A common tendency among these anxiety reactions is to try to **avoid** that which is feared.

   In reality, the patients who manifest these disorders have an **autonomic lability**, which predisposes them to have **quick reactivity** in response to environmental clues. They may have had an unpleasant vegetative experience in the past, such as blushing, dizziness, or fainting, in a stressful, or potentially dangerous, or traumatic situation. They may show **increased reactivity in the present**, such as hyperventilation, increased blood pressure, and heart rate.

In **fantasy**, or **imagination**, inconvenient, or stressful situations, are usually portrayed as more dangerous, or more stressful as they actually are.

The more so, by the patients who suffer from anxiety disorders.

However in their case, their **autonomic lability**, easily triggers fearful expectations, or vice versa, their fearful expectations easily elicit uncomfortable physical reactions.

Uncomfortable physical reactions further give rise to fear, which results in increased reactivity, followed by fleeing from what is feared (Lukas, 2000).

The well-known cycle of "**anticipatory anxiety**," can easily lead to a phobic reaction, as described by Frankl (1984b) in the book "*The Unheard Cry for Meaning*:"

> "A given symptom evokes on the part of the patient a fearful expectation that it might recur. Fear, however, always tends to bring about precisely that which is feared, and by the same token, anticipatory anxiety is liable and likely to trigger off what the patient so fearfully expects to happen. Thus, a self-sustaining vicious cycle is established: a symptom evokes a phobia; the phobia provokes the symptom, and the recurrence of the symptom reinforces the phobia (Frankl, 1984b; pp. 130-131).

Regarding development of anxiety disorders, Frankl (1984b; p. 131) explained that "One object of fear is fear itself: our patients often refer to '**anxiety about anxiety**.'"

Upon closer scrutiny, this "fear of fear" frequently turns out to be caused by the patients' apprehensions about the potential effects of their anxiety attacks: they are afraid that they may collapse, or faint, or they may get a heart attack, or a stroke.

Paradoxically, however, the fear of fear produces more sympathetic activity, and increases fear (Frankl, 1965b).

The most typical reaction to "**fear of fear**" is "flight from fear" (Frankl, 1965b). This happens when patients start to avoid those situations which arouse the anxiety. In other words, they try to run away from their fear.

This is the starting point for an anxiety neurosis: The "**Flight from Fear**", in reaction to the "Fear of Fear" completes a phobic cycle. In this cycle, every attempt to avoid the situation in which anxiety arises produces more fear (Frankl, 1965b), and the symptoms of phobia are maintained by the very mechanisms employed to avoid fear.

The only way to break the vicious cycle is to change one's attitude from "**wrong passivity**," to "**right activity**:" Instead of avoiding, confront that what is feared.

2. <u>Wrong Activity, Leading to Excessive Fighting Against Something</u>:

This pattern can be seen in the case of **obsessive ruminations**, and **obsessive-compulsive neuroses**. In its severe forms, the obsessive-compulsive pattern is diagnosed as **obsessive-compulsive disorder** (DSMIV, 1994; p. 423).

Obsessions refer to "recurrent thoughts, impulses, and images" (DSMIV, 1994, p. 423), which are distressing to the person and alien from them.

Compulsions are ritualistically or repetitively performed actions which are employed to neutralise the obsessive thoughts. They are usually seen by the patients suffering from the disorder as "distressing, time consuming, excessive, and unrealistic" (DSMIV, 1994; p. 417).

Patients who have obsessive-compulsive tendencies have an "**anancastic personality type**" (Frankl, 1984b) which means that they are habitually orderly, and scrupulous, with **perfectionistic tendencies**. They are sensitive to the environment, and easily manifest **autonomic lability** in response to traumatic and stressful situations.

As they would like to change themselves, or change others, they find that **pressure induces counter-pressure**, the counter-pressure increases the pressure—a vicious cycle is formed in which the more they fight against their symptoms, the more strength their symptoms seem to gain (Frankl, 1984b; pp. 131-132).

Others seem to grow resentful of their criticisms, or difficulties seem to mount the more one tries to fight them. As a result, their dissatisfaction grows with themselves, and with those around them. They can be locked into a pattern of resentment, anger, difficulty forgiving, and difficulty realising that one has limitations.

The process of the development of obsessive and compulsive disorder starts with some thought content reoccurring and "**getting stuck**" in the mind (as a result of fearful associations, autonomic hyper activity, or hyper-arousal). The content can be negative thoughts about oneself, or others, an experience of suffering, trauma, guilt, or bizarre associations, which one identifies as "unacceptable," or "wrong," or "inappropriate" and must be "undone" or fought against.

In this process, the original thought content receives **more attention**, and **significance**, thereby requiring more energy to be "**undone**." With the **vicious cycle** being complete, the capacities of the body and of the person are over-estimated, and consumed in a **fight against oneself**.

Whereas in the phobic cases, patients display "**fear of fear**," in the obsessive-compulsive neurotic cases they exhibit "**fear of themselves**." They fear that which they consider **unacceptable**. They are caught up by the idea that they may inadvertently harm someone, or commit suicide, or even homicide, and afraid that the strange thoughts that haunt them might be the signs of imminent, if not present psychosis.

The way to breaking the attitude of wrong activity, and excessive fighting against oneself is by acknowledging that everyone has weaknesses. However, focusing on the weaknesses only reinforces the problems. Noticing strengths, rather than weakness, and learning how to accept and **tolerate differences**, for the love of others, helps them change themselves.

In the case of obsessive compulsive disorder, the task is to learn how to engage in the **right passivity**. First, by recognizing, that the obsessive-compulsive character is **immunising against real psychosis** (Frankl, 1986). [A constant check of reality can not be a sign of break with reality]. Obsessive-compulsive character also immunizes against real immoralities, and harmful behaviours to others. [Excessive concern about others or oneself can not be a neglect of others]. Second, learning how to **comfortably ignore** thoughts that "get stuck" by not attributing any special significance to them (Frankl, 1984b; Lukas, 2000).

3. Excessive Forcing, Leading to Hyper-Intention:

Excessive forcing something may be manifested in excessive **defensiveness**, or **defending an idea**, often which can be related to **egoistic pursuits**, **power-**, **success-**, **control-**, or **pleasure orientation**. It leads to a **vicious cycle** in which the more one aims for pleasure, the less actual pleasure one finds. The reason for this is that excessive pleasure-seeking actually takes away from the experience of pleasure.

A desire gets satisfied, and disappears, where **boredom** results, until it arises again, in which case it has to be satisfied. The satisfactions start to become monotonous, and there is a never ending competition with oneself in one's own self-oriented experiences.

Instead of openness to others, and to the world, hyper intention leads to a **narrowing of the focus on oneself**, and to the present, which leads to unpleasant tension, and dissatisfaction. It leads to a **dichotomous view of the world**, and of one's abilities, in which world view everything becomes **relative**, and depend on **luck**, or **fortune**. The more control is aimed for, the more control seems lost.

Constant wanting and needing makes one **unable to let go**, and unable to stop the constant evaluation of "*what others have that I do not*." Consequently, excessive forcing, and hyper-intention, leads to **comparisons**, **frustrations**, and **unhappiness**. It leads to self-recrimination and constant **dissatisfaction** with life.

Hyper-intention in its most severe forms can be seen in **addictions** (i.e. alcohol abuse, DSM-IV, 1994; p. 196; drug abuse; DSM-IV, 1994; p.), where the addiction is a false means to living a meaningful life. The "desired end" in the self-reports of compulsive gamblers, for example, included statements like "*I wanted to fill my boredom*," "*I wanted to have a good time*," "*I wanted to win*," and "*I thought I had nothing to lose any more*" (Ungar, et. al., 1997, p. 5; Ungar, et al., 1998).

It is also an underlying factor in **sexual neuroses** (Frankl, 1986; Lukas, 2000), where the intention is self-satisfaction, rather than the true appreciation of the other.

The vicious cycle in hyper intention can be broken by learning how to **appreciate life**, and one's abilities as a **gift**, and **letting go** of some of one's desires and their fulfilment, for the sake of **loving somebody** (Frankl, 1986; pp. 132-175).

4. Excessive Attention, Leading to Hyper-reflection on the Self:

Hyper-reflection is the process of increasingly **monitoring one's performance**, which may start with one's **fear of failure**, or **fear of diminished performance**. The increased "**circling-around-oneself**" (Lukas, 1986; p. 38) produces a vicious cycle in that it leads to **hyper-vigilance** in an effort to guard off mistakes, and to **hyper-reaction** in response to minor failures. The resulting **anxiety**, on the other hand, may produce symptoms similar to those that are feared, **increasing the vulnerability** to future crises.

Excessive attention to oneself is unhealthy as it creates an **overly negative picture of the self**, and reflects this negative picture to others. It is a narcissistic restriction of the attention, which eventually leads to **dissatisfaction with oneself** and **excessive demands from oneself**.

> "Hyper-reflection turns minute everyday problems into catastrophes, and minor obstacles become insurmountable hurdles. The life of the person caught up in hyper-reflection becomes a confusion of countless terrible possibilities which could happen, and are a burden before they ever do happen" (Lukas, 1986; p. 38).

This pattern can be seen in the case of **sexual neuroses** (Frankl, 1952; 1962; 1984b), where the target of attention is the self; **insomnia** (Frankl, 1993), where the target of attention is one's sleep; and, to a more or lesser extent, hyper-reflection can be seen in the case of anxiety disorders (DSMIV, 1994; p. 393), mood disorders (DSMIV, 1994; p. 539), body dysmorphic disorder (DSMIV, 1994; p. 466), and hypochondriasis (DSMIV, 1994; p. 462).

A **positive** and **realistic self-image** is the best protector against hyper-reflection (Lukas, 2000).

However, it is often the case with some serious illnesses, and especially in the recovery phase of a psychotic illness, that patients have a realistic negative self image.

How can one help them break the cycle of self-observation?

First, we have to know that a realistic and negative self-picture depends on the **self**.

> The aim is for patients to build a picture of themselves that **does not depend on how they are**. They have to let go of their image of themselves, and look at the outer world: "*What is positive in the outer world, regardless of one's own self-image*?
>
> The possibilities in the outer world provide the building blocks with which a **new** self can be built, and a meaningful life can be lived. With this goes an attitudinal realization that "*even a broken candle can give light*"—every life can be made meaningful.
>
> With realizing some meaning possibilities in the world, the cycle of reflection on the self is broken, and the self-image can be naturally realistic and positive.

SUMMARY:

Whether in the case of psychoses, or in the case of neuroses, there are unhealthy attitudes which the therapist can discover in the background, which can contribute to the symptoms, and increase the suffering of the patients. The goal of the logotherapist is first to correctly identify the "stumbling-block" which restricts patients' abilities.

Next: To show an "alternate-route," through which patients can still lead a meaningful life, by being there for something, or someone.

Through engaging in the right activity, or right passivity, patients learn how to distinguish what is important from what is not so relevant. They understand that sometimes they do not have to take themselves too seriously. They can even perceive themselves with a sense of humour. They can ignore that which they desperately "want," or "hate," and forgo their resentments, when they learn how to look away from themselves, and become occupied not with how they are, but becoming oriented toward meaning.

The aim of modification of attitudes is to break the psychological chain-reaction within oneself, to give place to a dialogue with oneself, in which not only circumstances count, but, more so, what inner stand one takes towards them, how one handles oneself, and what one endures from what has to be endured.

As a rule, the therapist does not suggest the new attitudes. He or she only helps patients to identify those attitudes which have been unhelpful in the past, and highlight, and explore possible alternatives.

Only in extreme cases, such as threatening suicide, are therapists justified in suggesting new attitudes, when de-reflection is not possible, and the therapist tries to tip the scale toward life and meaning with his or her own argument (Fabry, 1994).

However, even in such cases, therapists can try to remain within the value system of their patients, and to suggest alternative attitudes from their patients' point of view, rather then on the basis of their own value-system.

Examples of modification of attitudes in the case suicide prevention is provided by Frankl, in the Chapter "On the Psychology of Melancholia," in the *Doctor and the Soul* (1986; pp. 200-216), and can be found in articles such as: "Logotherapeutic Approaches to Crisis Situations," by Boschemeyer (1989); "Staying Alive: A Logotherapeutic Approach to Suicide Prevention" by Salthouse (1993).

Articles on the use of logotherapy in crisis intervention include "Logotherapeutic Crisis Intervention" by Lukas (1993); "Logotherapeutic Crisis Intervention" by Long (1993); "Franklian Treatment with Traumatised Families" by Lantz and Lantz (1994); "Logotherapy and the Vietnam Veteran" by Lantz and Greenlee (1990); "Crisis Intervention and Logotherapy: A Case Study" by Freeman (1995); "Logotherapy and the Disabled: A Case Study" by Stavros (1991); "Trauma Therapy: A Meaning Centred Approach" by Lantz and Lantz (2001); .

3. Symptom Reduction:

The consequence of successful de-reflection and modification of attitudes is **symptom-reduction**: Symptoms either disappear, or they become more manageable. New attitudes help patients to accept fate so that they are able to bear it, or explore new response styles now available to them (Lukas, 1996).

In the seminar on "*Crisis Prevention*" (1996), and "*Crisis Intervention*" (2000), Dr. Lukas presented several case examples in which she illustrated how to foster attention "to what people know, and what they know well;" what is still intact, what is still possible; as well as **creativity**, **hopefulness**, **forgiving**; **reconciliation**; **trust**; and **gratitude**.

These are healthy attitudes which will immunise patients against future crises, help them to recover faster, and lead more fulfilling lives.

4. Orientation to Meaning:

When reduction of symptoms is successful, patients experience the positive and healing aspects of their new attitudes. At this point, they are open to a new orientation to meaning.

This phase of treatment is crucial, and very specific to logotherapy:

As we mentioned earlier, in logotherapeutic counselling, as in every therapy session, the therapist and the patient listen to each other as they dialogue. But, what is specific about logotherapeutic counselling is that the therapist is not only oriented towards the patient, but towards meaning. He or she listens for traces of meaning in what the patient says, and tries to invoke the patient's own powers in orienting themselves towards meaning.

The therapy is successful when both the therapist and the client orient themselves toward meaning, and as they dialogue, a creative discovery of what can be meaningful to the client in their specific situation can be discerned.

Meaning is not given by therapists, nor is it invented by the patient or the therapist.

Rather, in the process of logotherapy, meaning is discovered as a **joint venture** between the patient and the therapist.

While the way in which the discovery takes place will be described in a subsequent chapter entitled *Process of Logotherapy,* here we will present some principles which help therapists start the search for meaning.

According to Frankl (1986; pp. 105-175), meaning can be discovered in three areas of life.

These areas are represented by three major value categories—"**Avenues to Meaning"**--which when we realise them, and actualise, make our lives meaningful.

1. Creative Values: The first avenue to living a meaningful life is through **creative values** (Frankl, 1986; p. 117-131)--realising meaning by engaging in creative action. This is a way of giving to the world, and using our talent to make and create something that did not exist before, or to make a contribution. Work falls into this category. However, Frankl (1986) points out that it is not the type of work per se which counts, but the manner in which we perform it. Each one of us, in our own respective fields, within our own tasks, or duties, carry the possibility to contribute our unique talents, and interests in a constructive manner, in whatever large or small way, when it serves for the advancement of our families, society, or of humanity.

2. Experiential Values: The second avenue to living a meaningful life does not require action, or creation. It is the opposite: it is through what we take from the world in the form of **experiential values** (Frankl, 1986; pp. 132-175). Experiential values are evidenced by contemplating or enjoying the beauties of creation, or experience a loving bond with another person. Love, for example, is an experiential value, with many dimensions and rich meaning possibilities, which Frankl (1986) wrote extensively about. Also, in relation to experiential values, Frankl (1965) remarked that when we review our lives with regard to our experiences, it may seem like a series of ups and downs. However, just like mountains are not estimated on the basis on the number of all the peaks, but just by the tallest peak, even if our life was not rich with happy memories, we may still count that unique experience for which we can say that it was worth living [as applied in the "Mountain Range Exercise," described in Chapter IX].

3. Attitudinal Values: The third avenue to experiencing meaning is "special" among all the three categories, in that it is available under all circumstances, and it does not require the ability to create, or to experience. This category is termed "**attitudinal values**" (Frankl, 1986; pp. 105-116).

   Attitudinal values refer to the stand we take toward fate, and to circumstances which are beyond our control, and can not be changed. It is the ability to face suffering with courage, and in dignity when confronted with unchangeable events.

   Choosing our attitude occurs at the depth of our spirit, where we still have an area of freedom. This last area of freedom exists until one's last breath. It means that life can be lived to the full not only in creating and enjoying, but in suffering, as suffering creates a distance between us and that which is suffered, and makes us aware of what not ought to be, to truths, which leads to growth, or presents an exemplary way to others. As such, facing truly unavoidable fate with dignity becomes the highest form of human sacrifice, and human achievement.

During the completion of her Doctoral Degree, in 1972, Dr. Lukas conducted a research study in which she explored how people perceive meaning, which eventually led to a **validation** of the above mentioned three avenues to finding meaning in life.

Based on the results, she developed the *Logo Test* (Lukas, 1972; 1981), which measures how people find meaning in the attitudinal, creative, and experiential areas of their lives. Also, she gained important insights into the significance of these value categories in her therapeutic work. Namely, she realised that: (1) All of the value categories are of equal value, and involved in all aspects of living meaningfully;
(2) Attitudinal values provide the area of last freedom, and ultimate dignity in human life, in which there is an opportunity to transform a tragedy into a personal triumph;
(3) People intrinsically strive for these aspects of meaning fulfilment.

In her own words:

> "I discovered this when I was working on my dissertation. I asked 1,000 persons selected at random what they considered the most important meaning in their present lives. All answers, diverse as they were, could be classified, without exception, within one of the three values. In round figures, 50% were creative, 25% experiential, and 25% attitudinal. For this reason, I speak of an 'active' and 'contemplative' half of the human meaning-horizon.
>
> I did not immediately realize that here was the key to the paradox because I misunderstood the equal rank of the three values to be either-or. In reality, it is not that we realize one value, or another, but everything we realize—all that is positive, good, and meaningful—belongs to the totality of the value-triad. Equal rank does not mean the three exist next to each other, but that they make up a unity, with differing emphases, with room for every meaningful human thought, act, striving, feeling, and suffering.
>
> This helps me to make use of the logotherapeutic value system in counselling. I no longer think I must motivate clients to realize one of the three values—this only arouses resistance. I know now that everything positive in the clients' lives is reflected in the totality of the value-triad; I need only to help them find the positive, for them to realize their lives are filled with meaning. It is a mistake to believe that every life is "empty" or "full" of meaning, like a sack with few or many socks. Life has meaning under all circumstances even when unnoticed. We have to draw the attention of the suffering client to what is left instead of what is missing. There is a great deal left--in every situation" (Lukas, 1986; p. 140).

In addition to the three "avenues" to finding meaning in life, there are **five** "**stepping stones**" (Wilson, 1995; p. 6) to discovering where meaning is likely to be found. They represent "*Specific Logotherapeutic Guidelines in the Search for Meaning*" (Ungar, 1999). On the basis of Frankl's writings, they were first detailed by Dr. Joseph Fabry (1968, 1994), followed by a description by other logotherapists:

1. Self-Discovery: "Every time we discover truth about ourselves, meaning shines forth. We have an 'Ah-hah! experience.' We get a glimpse of the authentic self beneath all the shells and the masks which we have put on for self-protection, not only against who we are but also against who we can still become. When we respond to meaning of the moment as an authentic self, the meaning, too, will be authentic" (Barnes, 1995d; p. 16).

Examples of guided self-discovery for individuals and groups (i.e., Eisenberg. 1982; Eisenberg, 2000; Ernzen, 1986; Sahakian, 1986; Ward, 1990) include the use of a logotherapeutic technique called *Socratic Dialogue* (Wilson, 1995; Lukas, 2000), which technique we will describe in a subsequent chapter. Its essence lies in a dialogue with patients in which they can discover truths about themselves.

"*A Workbook to Increase Your Meaningful and Purposeful Goals (MPGs)*" was developed by Hutzell, and Jerkins (1995). The "*Logochart*", a workbook, a therapeutic technique, and homework assignment for helping patients realise ways in which they avoid taking responsibility, and helping them to discover the "Authentic Self," aside from their "Automatic Self," was developed by Khatami (1988; p. 67).

2. Choices: "Choices are the second circumstance in which meanings become apparent. You may be trapped, but you are not without a choice (Long, 2000). Fabry quotes Frankl, 'The conditions do not determine me, but I determine whether I yield to them or brave them.'(*Pursuit of Meaning*, p. xix). If a situation can be changed, the 'meaning of the moment' is to change it. Even in a situation that is unchangeable, you have a choice—you can change your attitude toward that particular situation. The more choices you see in your situation, the more meaning will become available" (Wilson, 1995; p. 6).

> "Whenever we feel trapped, life seems meaningless. To list our choices, even the less practical and the ridiculous, helps to discover the meaning of the moment. And we must remind our clients that their choices include changes in attitude in situations which themselves cannot be changed" (Barnes, 1995d; p. 16).

In the article entitled "*Human Dignity and Psychotherapy*" Dr. Lukas (1984b) presents her so called "*Bear-chart*" (p. 80), which is a systematic and illustrated exercise guide for patients to gradually learn how to rely on their own resources in managing their emotional crises by becoming more aware of their choices. It consists of five illustrated cards with questions to answer: (1) "*What is my Problem?"* (2) *"Where is my Area of Freedom?"* (3) *"Which possible Choices do I have?"* (4) *"Of these which is the most meaningful?" and* (5) *["I want to actualise this one*!"] *"What is the First Step in the Chosen Direction?"* Patients are taught how to slow down, and before responding hastily, automatically, and habitually, to reflect on what it is that they really want to achieve through more authentic, thought through, and meaning-oriented decisions.

3. Uniqueness: "Uniqueness is the third guidepost in finding meaning. Being creative manifests uniqueness, or, by being unique, creativity surfaces. We are all specialists—in a special world. Logotherapy sees persons as unique in their lives; and life, as a string of unrepeatable situations. In moments when we become aware of personal uniqueness, meaning becomes apparent" (Wilson, 1995; p. 6).

> "Whenever we feel that we are replaceable—by someone else, or worse, by a machine—life will seem meaningless. We have to find areas where we are irreplaceable, even though on a small scale. The two areas where our uniqueness is most likely to be seen are human relationships and creativity. Only you can make this particular painting, sculpture, or poem. The relationship may not be ideal. The painting, a masterpiece, but is exclusively yours" (Barnes, 1995d; p. 17).

Reflecting on one's uniqueness, and realizing one's singularity adds to seeing life as valuable, unique, and un-repeatable. It helps to see every person as **irreplaceable**.

In the article entitled "*Four Step Model of Logotherapy*," Ungar (1997; pp. 113-119) illustrates how uniqueness and singularity can be apparent in reflections on one's life, even with tragedies, and the way in which such reflection can be used to enhance meaning-oriented growth through (1) *Evaluating clients' lives in terms of 'gifts' received*; (2) *Pinpointing hardships as opportunities to respond*; (3) *Highlighting clients ability to respond to their inner call*; and (4) *Supporting decision-making and commitment to action*.

Realising one's uniqueness can be also helpful in resolving **value-conflicts**, such as in the following example:

> "Take a certain morning. Shall I devote myself to my wife or look up a patient at the hospital? The conflict disappears when I can see that the value of my personal visit for the sake of the sick is higher order than just being with my wife. But suppose she needs me because she is too sick. Then the choice seems to be one sick person against another. But there is a difference, because in one case I am replaceable, and in the other I am not. In the case of my patient at the hospital I can send another member of my staff to look after him. Such questions as 'Who is replaceable?' and 'Who is unique in this situation?' carry great weight in deciding value conflicts" (Frankl, via Fabry, 1994; p. 62-63).

Dr. Lukas (1996; 2000) demonstrated the use of the "*Method of Common Denominators*" is deciding value conflicts, which relies on the recognition of one's uniqueness, and the impact of one's decisions on others. We will present this technique in more detail in a subsequent chapter on the *Techniques of Logotherapy*.

4. Responsibility: "Responsibility represents the fourth circumstance where one can find meaning. Your life will be meaningful if you learn to take responsibility where you have freedom of choice, and if you learn not to feel responsible where you face an unalterable fate" (Wilson, 1995; p. 6).

> "To respond to the meaning offerings of the moment is to act in response. Frankl distinguishes two kinds of responses: one which follows outer guidelines—those of parents, society, custom—which he calls responsibility. The other follows our inner guidelines, but it must be remembered that in ordinary situations, the inner guidelines usually coincide with the values of society. To do one's duty is as meaningful as to follow one's commitments, if we accept the duty as a meaningful response to a situation. Meaning is not automatically found by rejecting outside authority, but some responsibility is needed. Freedom without responsibility does not result in meaning, but in chaos" (Barnes, 1995; p. 17).

As we see in Dr. Lukas' (1984b; p. 80) "Bear-chart," and Socratic Questioning, freedom of choice has to be coupled with responsibility to lead to actualising meaning: "*Which is your first step in the direction you have chosen*?"

Another advice on pondering our responsibility is to "…*live as if you were living for the second time and had acted as wrongly the first time as you are about to act now*" (Frankl, 1984b; p. 151).

> "For as soon as we lend our minds to the essence of human responsibility, we cannot forbear to shudder; there is something fearful about man's responsibility. But at the same time, there is something glorious! It is fearful to know that at this moment we bear the responsibility for the next, that every decision from the smallest to the largest is a decision for all eternity, that at every moment we bring to reality—or miss—a possibility which exists only for the particular moment. Every moment holds thousands of possibilities, but we can choose only a single one of these; all the others we have condemned, damned to never being—and that too, for all eternity. But it is glorious to know that the future, our own and therewith the future of the things and people around us, is dependent—even if only to a tiny extent—upon our decision at any given moment. What we actualize by that decision, what we thereby bring into the world, is saved; we have conferred reality upon it and preserved it from passing" (Frankl, 1986; p. 35).

5. Self-transcendence: "The fifth and therapeutically the most useful area where meanings can be found is self-transcendence, the human capacity to reach beyond ourselves to other people in love and other causes to make our own. It is not a call to become unselfish as such, but to include others in our own interests. By doing things for others, people help themselves even further. This is therapeutically important because it provides help in exactly the area where people feel defeated: only an alcoholic can help other alcoholics by his example; a divorcee can help other divorcees; a person in a wheel chair, others in similar circumstances (Barnes, 1995, p. 18).

POINTS TO PONDER:

* Recount an example where you found meaning through your creativity.

* Recount an example where you found meaning through loving someone, and feeling loved by them.

* Recount an example where you could not change your situation, but you decided not to give up!

(3) The Follow-up Phase:

Lukas (1996) pinpointed that, while the relevance of the diagnostic and therapeutic phases is evident in therapy, the significance of the follow-up stage is yet to be recognized.

The task of the therapist during the follow-up period is to monitor patients' condition until their healthy patterns are well established. The situation in which they are discharged might not be ideal. They may find life more stressful than they can handle, or they may have more free time than before that they would have to learn how to fill. Stress from over-demand, on the one hand, and hyper-reflection from too much leisure, on the other hand, can lead to patients' relapsing into their former unhealthy patterns.

From a logotherapeutic perspective, Dr. Lukas (1986) proposed broadening clients' value base, and helping them to discover unique meanings as two ways of reducing the chances of relapse. In this process, logotherapy's techniques, and meaning-oriented dialogue forms can be helpful, which we will consider in the subsequent chapters:

> "In applying Logotherapeutic principles during the three phases, one must realize that there is no such thing as a specifically logotherapeutic diagnosis; in therapy more is needed than logotherapeutic techniques; and the follow-up requires knowledge that goes beyond logotherapy. While it is true that pure logotherapy is not enough for psychological counselling, it is also true that such counselling is incomplete without the application of logotherapeutic principles. These principles are not universal guidelines but a professional supplement to optimal living, regardless of the approach used" (Lukas, 1986; p. 36).

POINTS TO PONDER:

"*True friend is the person who can understand the melody of your heart, and can remind you of it when you have forgotten about it*" (Lukas, 2000).

* Have you ever been is a situation where you have done quite well up to a certain point, at which you started to feel frustrated, stuck, fearful, or resigned? Was there a time when you needed to withdraw, and to think, and to find comfort in the company of someone who cared about you? Maybe not much was needed for you to recover your strength, but it was enough to know that one person believed in you. Maybe, you did not need to hear many words of encouragement, but just the one thing which was so crucial to you. Other times, silence may have spoken to your heart. –It is good to know that we can count on someone to be with us when we need it the most.

Chapter VII: Specific Logotherapeutic Techniques

During the therapeutic phase, logotherapists have two specific techniques at their disposal, originally developed by Dr. Frankl for the non-specific treatment of neuroses: **Paradoxical Intention** and **De-reflection**. A non-specific technique, **Modification of Attitudes**, is a technique specifically applicable for the treatment of noogenic neuroses.

(1) Paradoxical Intention:

Frankl developed paradoxical intention before World War II and published in case histories in 1939 in the *Schwitzerische Archiv fur Neurologie und Psychiatrie* (Swiss Archives for Neurology and Psychiatry). In the *Unheard Cry for Meaning*, (1984b), he claims to have used this technique as early as in 1929, and published it scientifically in 1939. He included it in the logotherapy literature in 1956 (Frankl, 1984b), and continued to refine it over the following years (Guttmann, 1996).

Since its original publication, paradoxical intention as a technique has been used with increasing frequency, and with good results, especially in the treatment of patients who suffer from **phobias** and **obsessive-compulsive behaviour** (Guttmann, 1996). It has also been used whenever patients' symptoms are due to underlying unhealthy attitudes, such as the ones we identified earlier in the chapter on the *Therapy Phase of Logotherapy,* whereby we noted that *excessive avoidance* and *excessive fighting against* (coupled with *hyper-intention* and *hyper-attention)* are directly related to the origins of **fear** and **avoidance reactions**, as well as many other **anxiety states**, such as obsessions and compulsions, which can also result in difficulties of social functioning, and strained interpersonal relations.

While paradoxical intention has been used in other treatment approaches, for example, it is known in cognitive and behaviour therapy's in vivo sensitisation, graded exposure exercises, and suggesting the paradox, these techniques have been developed slightly later than logotherapy's paradoxical intention, and there are a few markers which distinguish logotherapy's paradoxical intention from the "paradox" as known in behaviour therapy.

The essence of logotherapy's paradoxical intention is that **fear and wish are incompatible**. Direct intention cancels out fear. We can not fear that which we wish, and therefore, directly intend to happen.

As you will notice, the objective of this approach is to break the pattern of anticipatory anxiety (Frankl, 1984b), which as you recall from the previous chapter, often manifests itself in 'anxiety about anxiety,' coupled with anxious self-observation, and fear of the physical consequences of fear, which continues to increase autonomic nervous activity, lead to a sensation of "*impending doom*" and avoidance, reinforcing the same symptoms which are feared. Alternatively, fear of fear may increase attempts to fight off the fear, resulting in even greater fear of the "return" of the object of fear—fear itself.

During its first step, paradoxical intention is similar to other behavioural techniques: Its aim is to help patients not to avoid fear, but to face it, by directly intending that which is feared.

However, paradoxical intention goes even further: Patients are helped to face their fear, possibly with a **sense of humour**, which is one of the resources of the human spirit. In this way, they are taught to ridicule the situation--but not themselves, which counter-mechanism takes the "*wind out of the sails of the phobia*" (Frankl, 1994; p. 168).

> A simple example of paradoxical intention in the case of sleeplessness, for example, was demonstrated by Frankl in front of the audience (Frankl with Evans, 1985), in a dialogue with a fictitious patient, which we will paraphrase: Mr. G. is anxious about not getting enough sleep and he worries that tomorrow he is going to have a difficult day at work. The more he tries to force his sleep to come, sleep does not come, and he lies awake thinking about what his colleagues and co-workers are going to think the next day, and how anxious he is going to be to cover up for the signs of his worries. He is known to be a very conscientious employee, and he fears that he is going to stumble on his words, and confuse all his notes, unless he gets a good night's sleep. Instead of trying to force himself to fall asleep, Frankl would advise Mr. G.: Let's try something else: "*You have always worried about jour boss and what he will say to you. Let's try once in a while the opposite. Let's see if you for example could say to yourself:* "*Tomorrow, I will see if I can make a difference at my workplace. I want to prepare a little surprise for my boss. I want to convince him that instead of the ordinary, neat guy that he thinks that I am, I can excel myself. I can beat all of his expectations if I manage to convince him, that I am an expert stutterer, and expert looser, and I can do the two things at the same time. Just imagine his reaction! So, it does not matter if I can't get any sleep now, in fact the less sleep I get today, the more convincing I can be tomorrow!"* Seeing the smile on the face of the audience, Frankl noted, "…you see, just as you smile now, the patient's smile tells me that he is already feeling better. For whoever can laugh about his symptoms is already on the road to recovery."

Paradoxical intention with severe anxiety disorders usually follows the following sequence:

> **1. Rule out any underlying medical concern that can cause the anxiety;**
> **2. Self-distancing from the symptoms to gain perspective;**
> **3. Detailed explanation of paradoxical intention and the sharing of case histories;**
> **4. Collaborative creation of exaggerated symptoms in ways that appeal to the patient's unique sense of humour;**
> **5. Role playing the humorous formulations during therapy sessions until the patients' sense of humour is fully activated;**
> **6. Practicing the humorous formulations before-, or in actual fearful situations.**

Since autonomic lability is a factor in the panic-reaction, and patients' fears are easily triggered, the actual process takes place in a safe setting, after good rapport has been established. First, there has to be a confirmation that their anxiety is not related to some other illness, such as a result of endogenous depression, hypothyroidism, diabetes, infectious diseases, or other illness which needs direct immediate attention.

Self-distancing is accomplished by helping patients to relax, and teaching them self-regulation, and relaxation techniques. The core of self-distancing is also a careful re-construction of the fearful symptoms and the circumstances when they occur, and what patients have tried before to cope. The general principle for this dialogue is the "*alternate diagnostic method*" of Lukas (1986), whereby the therapist combines questions about the symptoms and worries with coping-related questions and soliciting the recall of positive experiences, and resources.

Naming the concerns is relevant as it helps to identify what patients' symptoms of panic have been, and what resources they have. It brings relief for patients to be able to talk about this, but without the need to analyze in considerable detail what triggered their anxiety, or to look for the particular source of it. The sources of the anxiety are rarely found, and if they are uncovered, a solution is still lacking, resulting in a lot of suffering, which can be avoided if the patient is willing to move forward, and to find a solution to these symptoms by taking them on the surface at face value. The changes will be deeper than surface-level, when the solution can be found, and sense of self-efficacy increases, with which there are more resources to handle eventual further difficulties.

Detailed explanation of the mechanism for paradoxical intention, and case stories can be found in several of Frankl's books, including *Man's Sear for Meaning* (1984), the *Doctor and the Soul* (1986). Related case examples are described in his books, the books of Dr. Lukas, and other logotherapists. Selected articles of the *International Forum for Logotherapy*, which deal exclusively with this topic, include those by Ascher, 1980; Bazzi, 1979; Hooper, et al., 1996; Leslie, 1994; Yoder, 1983; and Yoder, 1994.

Paradoxical intention was reportedly successfully applied in a variety of cases, such as obsessive-compulsive disorder (Frankl, 1986; pp. 184-199); writer's cramp (Frankl, 1962; p. 125); strong shaking (Heines, 1997; pp. 7-8); urinary retention (Ascher, 1980; pp. 13-16); inferiority complex (Yoder, 1994; pp. 108-114); fear of elevator riding (Lukas, 1986; pp. 76-77); fear of crowded streets (Lukas, 1986; pp. 76-77; Hooper, et al. 1996); tics (Frankl, 1984b; p. 147); claustrophobia (Frankl, 1984b; p. 141-142); fear of flying (Frankl, 1984b; p. 134; Guttmann, 1996; p. 80); fear of sleeplessness (Frankl, 1962; pp. 128-129); automobile phobia (Heines, 1997; p. 7); stuttering (Guttmann, 1996; p. 81), and social anxiety (Frankl, 1984b; p. 146). Jindal, et al. (2004), in a recent article of the *American Journal of Psychiatry*, reported that two meta-analyses with randomised control trials proved paradoxical intention efficacious in the treatment of insomnia.

According to Lukas (1982), paradoxical intention has three distinct "birthmarks," which make it a speciafically logotherapeutic technique: First, it achieves, **modifiaction of attitudes**:

> "It achieves calmness in the patient, a return to basic trust that had been lost, a fundamental confidence that things will fall into place even if we humans don't always understand how. Paradoxical intention brings about a humility that has almost religious undertones—the realisation of our own shortcomings which are embedded in a universal order of meaning. A woman who can say to herself 'All right, if I have not locked my door, then let it be open, gapingly wide open, so a whole procession of thieves can walk in and rob me blind,' such a woman is made to feel the relativity of possessions and material values. She is gently reminded that we humans are mere specs of dust in the works of the world and of time, and that our presumed treasures are insignificant within an infinite universe. A man who smilingly imagines presenting his boss with a sizeable puddle of sweat or bombarding him with a broadside of stuttering babble is a man who has realised that there is a higher authority than the boss, and that the boss is merely a human being.
>
> The profound testimony of these exaggerations is the ridiculousness of wasting precious minutes of our lives on such trifles instead of saving our emotional reactions for important things that remain unattended. Without a change of our inner attitudes, without a shift of our attention from the small to the big, paradoxical intention can not be accomplished. Therefore, the emphasis of this method is on the word 'intention' and not on the technique of the paradox which is used, in many variations, by many psychotherapists" (Lukas, 1982; p. 21).

Another characteristic of paradoxical intention is the **dialogue with oneself:**

For a long time, psychology was dominated with insight-oriented techniques, and discovering a dialogue within oneself. An innovation from logotherapy comes not from trying to understand the self, but **influencing it** (Lukas, 1982). This presupposes the logotherapeutic principle, according to which a meaningful dialogue can take place, with the spirit in control of the self, and the dimension of psyche controlled by hidden forces.

> "One of the best examples come from the founder of logotherapy in the form of paradoxical intention and its self-dialogue between the spirit and psyche. 'Good morning grouch' one patient will say to himself when he wakes up in the morning, depressed and in low spirits. 'Go ahead and spoil my day. We'll see if you succeed! But put a little effort behind it, will you—it's no fun fighting a pushover.' 'Now finally I have a reason to get mad,' another patient will tell herself after having dropped a cup of coffee.' 'I always get mad with no good reason, now I can enjoy my anger because it is justified!' Such short dialogues with the self immediately chase away the negative mood, which, paradoxically, was intended" (Lukas, 1982; p. 23).

Paradoxical intention also helps to detangle and to handle complex**, vague fears**, which have no known reason, and which come and go occasionally, and arise out of one's own psychological self-talk, which is anxiety provoking. Again, one can rely on the dimension of the spirit:

> "*'Where in the world did I leave my fear today? It would be awful if I had lost it somewhere and couldn't find it any more. It's been a steady companion, and I'd miss it terribly'*" (Lukas, 1982; p. 23).

The third, distinctive feature of paradoxical intention is the use of **humour** (i.e., Shaughnessy, 1984; Bulka, 1989; Paden-Levy, 2003).

As we mentioned before, humour is a resource of the human spirit. The place of humour in meaning-oriented therapy can be understood with the metaphor that humour is like a thin wire which spans between the human orientation toward sense and nonsense (Lukas, 1982):

> "When we laugh about a joke, we do not laugh about a nonsensical string of words [which patients are asked to repeat, and practice] but about the kernel of sense behind the nonsense in which we perceive meaning, we 'understand the joke'"(Lukas, 1982; p. 24).

This is what most essentially distinguishes paradoxical intention from autosuggestion:

> "Those who can laugh about their symptoms have overcome them. They are carried off, from their sickness and misery, on the wings of the spirit, which remains unaffected by the torments of the psyche" (Lukas, 1982; p. 24).

According to Frankl (1986), since paradoxical intention is a **non-specific technique**, it can be applied both in severe cases, and in resolving minor obstacles. Its durability is not linked to the length of therapy, and therefore it can be used effectively in short-term therapy. It is also easy to combine it with other treatment modalities, which is the preferred way of using it (Frankl, 1986).

Frankl (1986) cautioned that paradoxical intention is **not a panacea**, and not every psychotherapist can use the technique with equal skill. Specifically, Lukas (1986) and Fabry (1982) noted that using paradoxical intention seems only simple in theory. In real life and practice, one should be aware of the difficulties of its application: It is not simple to bring about a wish for which the patients experienced so much horror in the past. For such a wish to happen freely, the human spirit must be activated, and humour—the antidote of fear—needs to be applied.

Lukas (1986) noted that the first few times that patients practice their formulations, they tend to be sceptical, and hesitant. They do not know whether to laugh or to weep. They do not really know what will happen, and they feel insecure. Many patients expect the therapist to explore their past, interpret their dreams, analyze their childhood—rather than to challenge their fears in a humorous manner. That is why the initial phase is highly critical, and the therapist must take every effort to consider the individuality of each patient.

According to Lukas (1986), experience helps therapists to find the right formulations, the only caveat for therapists is that their formulations must never be manipulative, or ridiculing the patient. The best formulations are always based on the bridge between patient and therapist. This bridge trust must not be shaken, or over-challenged, because it is through this alliance that patients' trust can be regained.

Pharmacotherapy can be complemented with logotherapy's paradoxical intention, in the treatment of obsessions and compulsions, and in the treatment of phobias (Frankl, 1986). However, there is strong contraindication for the use of paradoxical intention in the case of blasphemous obsessions, where logotherapy should be used as a complement, appealing to the defiant power of the human spirit.

Paradoxical intention can not be used in the cases where there is no access to the resources of the human spirit, or where there is a temporary block to activating the resources of the spirit.

It is particularly relevant to **refrain** from the use of paradoxical intention in the case of psychotic states, including psychotic depression, where the goal of therapy is rather directly oriented toward the aspects of the personality that remain healthy, and the aspects of the body and psyche which have become affected by illness are open to pharmaco-therapy. The logotherapeutic approach to psychotic conditions is based on self-detachment, and taking healthy attitudinal stand toward the symptoms (Frankl, 1986).

The same applies for conditions in which patients experience much emotional turmoil, and their condition needs to be stabilized before meaning-oriented therapy can take place. As such, paradoxical intention is contra-indicated in the case of patients who exhibit suicidal tendencies, thus, patients who are either at risk, or actually have a tendency of harming themselves, or others.

CASE EXAMPLES:

Case 1: Fear of Excessive Perspiration.

> Frankl (1962) tells about a young physician who came to him complaining of his fear of perspiring. He was suffering from this phobia for four years prior to his consultation with Frankl. He told Frankl that whenever he expected an outbreak of perspiration, his anticipatory anxiety caused him to experience exactly what he was afraid of—excessive sweating. Frankl advised him to resolve deliberately to show people how much he could sweat—to cut the vicious cycle. When the doctor came back a week later, he reported to Frankl that whenever he met anyone who triggered his anticipatory anxiety, he said to himself: 'I only sweated out a quart before, but now I am going to pour out at least three quarts!' Reportedly, after all those years of fear, he was able to free himself permanently from the phobia (Frankl, 1962; p. 124; cited in Guttmann, 1996; p. 78).

Case 2: Bacteriophobic Obsession.

> A thirty-five-year-old woman was admitted to the Vienna Poliklinic Hospital. She reported that she had been suffering from bacteriophobic obsessions and severe washing compulsions, for several years. Lately, her condition reportedly grew worse, to the extent that she had to be hospitalised because of several attempts of suicide. She said that life was hell for her because of her fear of bacteria. She washed her hands hundred times a day. Fearing contact with germs, she no longer left the house, and did not allow her husband to touch the children, in the fear that he would infest them with the germs. She requested a divorce because she felt she had made her family unhappy. Her life was virtually incapacitated as she was unable to do any housework and stayed in bed all day.
>
> During the first stage of treatment, entitled 'arousing hope', Frankl asked the woman about the symptoms of her obsessions. It was because of her fear, which she thought was the symptom of psychosis, that she fought them. Frankl pointed out to her that the symptoms of her obsession indicated that she belonged to a certain type of character structure, which is called 'anancastic' and that this personality structure immunizes her from real psychoses: "You have no reason for such fear. Any normal person can become psychotic, with the single exception of people who are anancastic character types. I cannot help but tell you this and destroy all your illusions in this respect. Therefore, you need not fight your obsessive ideas. You may as well joke with them" (Leslie, 1994; p. 117). Upon which, the patients response was a sigh of relief.

Frankl referred to the second stage of therapy as 'changing perspective.' This was accomplished by using paradoxical intention. Frankl turned to the patient, and invited her to follow what he was about to do: He stooped down and started to rub the floor with his hands saying: "After all, for the sake of change now, instead of fearing the infection, let's invite it." (Leslie, 1994; p. 117) Frankl continued to rub his hands vigorously on the floor, and then rubbed his hands on his face, asking the patient to follow his example. She had hesitantly gotten up from her chair, gotten down slowly on her knees beside him, and began to rub her hands on the floor. He encouraged her to "rub harder" and then to rub the germs off her hands and onto her face. As she did so, a strange expression came over her face. Frankl noticed it and turned to his audience saying: "Do you see, she is smiling. She is getting better already" (Leslie, 1994; p. 117).

Dr. Leslie, who was Frankl's student reported that the most dramatic change could be observed when Frankl invited her to sit back into her chair and talked with her about her children and her love for them. She spoke calmly and confidently. There was animation in her voice and on her face. When she got up, she left the room with her head held high (Leslie, 1994; p. 118).

Frankl noted that after the treatment, she was able to joke about her fear. It would not have been accurate to say that she was completely free of symptoms, for an obsession may have entered her mind. However, paradoxical intention has been clearly successful in cutting the vicious cycle that haunted this woman for several years (Frankl, 1962; p. 126).

Case 3: Unexplained Heart-Palpitations.

"Mary B. who had been undergoing various methods of treatment for eleven years, yet her complaints, rather than being alleviated, had increased. She suffered from attacks of palpitation accompanied by marked anxiety and anticipatory fears of a sudden collapse. After the first attack, she began to fear that it would recur, and, consequently, it did. The patient reported that whenever she had this fear, it was followed by palpitations. However, her chief concern was that she may collapse in the street. Dr. Kocourek advised her to tell herself at such moment: 'My heart shall beat still faster! I would just love to collapse right here on the sidewalk!' Furthermore, the patient was advised deliberately to seek out places which she had experienced as disagreeable, or even dangerous, instead of avoiding them. Two weeks later, the patient reported: "I am quite well now and feel scarcely any palpitations. The fear has completely disappeared. Some weeks after the discharge she reported: "Occasionally mild palpitations occur, but when they do, I tell myself: 'My heart should beat even faster!' and at that moment the palpitations cease" (Frankl, 1986; p. 226).

(2) De-reflection:

While paradoxical intention is based on logotherapy's concept of **self-distancing**, de-reflection relies on the concept of **self-transcendence** (Frankl, 1993). As we mentioned in the previous chapters, self-transcendence means that we are able not only to distance ourselves from our internal and external conditions, but also to reach beyond ourselves (Fabry, 1994). By being immersed in love and work, or be responding to a situation by choosing the right attitude, we are transcending ourselves.

Dr. Frankl developed de-reflection to help his patients deal with dysfunctions and cumbersome behaviour patterns that are brought about, and intensified, by their own hyper-intention and hyper-reflection. In his view, hyper-intention is unhealthy for two reasons: First, because there are certain experiences, such as "**love, hope, faith**, and **will**," which cannot be "*demanded, commanded,* or *ordered*," and cannot be made the target of intention, lest they result in a manipulative approach to life; and second, because certain phenomena, such as **happiness** and **success**, can not be directly pursued, or otherwise they lead to the an end in themselves (Frankl, 1984; p. 85).

In this respect, he presented the following explanation:

> "Relaxation too eludes any attempt to 'manufacture' it. This was fully taken into account by J. H. Schultz, who developed systematized relaxation exercises. How wise was he, when he directed his patients, during these exercises, to imagine their arms becoming heavy; this automatically induced relaxation. If he had *ordered* these patients to relax, their tenseness would have increased, because they would have intensely and intentionally *striven* for relaxation. It is not different with the treatment of inferiority feelings: the patient will never succeed in overcoming them by way of direct attempt. If they have to get rid of anxiety feelings, they have to go, so to speak, on a detour, for instance, by going to places, despite inferiority feelings, or by doing a job, in spite of them. As long as they centre attention of the inferiority feeling within themselves, and 'fight' them, they continue to suffer from them; however, as soon as they focus attention on something outside of themselves, say a task, the inferiority feelings are doomed to atrophy (Frankl, 1984; pp. 86-87).

This statement is relevant, as Lukas (1987) characterised hyper-intending and hyper-reflecting individuals as persons who **lack self-confidence**, and who pay undue and exaggerated attention to their own health, behaviour and thoughts, which preoccupation is "*hazardous, because the more one is searching for signs and symptoms of sickness, the more one is likely to find them*" (Lukas, 1996; p. 10).

According to Lukas (1987), human suffering is inevitable, yet, some suffering is unnecessary. Such unnecessary suffering is the one that is brought on by hyper-intending and hyper-reflecting patients on themselves, often unintentionally: The more they try to avoid their suffering by assuming control and monitoring, the more they suffer from the wrong outcome of their actions.

Related to the concept of suffering, Dr. Lukas (1980) explained that, in logotherapy, the two kinds of suffering—inevitable--, and–unnecessary suffering—are approached with two different techniques: **Modification of Attitudes** can be used to help patients face **inevitable suffering**; and **De-reflection**, to help them break, and alleviate **unnecessary suffering**.

Frankl first described the technique of de-reflection in the article "*The Pleasure Principle and Sexual Neurosis*," in 1952. In this study Frankl stated the he found that hyper-intention, which is so common in our days, paradoxically produces the opposite result:

> "The more people run after happiness, the more happiness is running away from them. Thus begins a circle comprised of the following elements: A desired aim is directly strived for, and intended to such extent that we can speak of hyper-intention. Most often this hyper-intention is accompanied by much self-examination, self-observation, and contemplation about oneself, what Frankl called 'hyper-reflection.' When both of the preceding behaviours are coupled with anticipatory anxiety, or fear of not being able to produce or attain the desired goal, or when one intends to grab pleasure and happiness by force, and these fly away—as they always do when people reach for them—a pathological basis is formed as a vicious cycle that only increases the disturbance. To counteract these elements and to break out of the vicious cycle, centrifugal forces must be brought into play, meaning that instead of hyperintending (to gain pleasure) one should give him-, or herself to the other; instead of hyperreflexion, one should forget about oneself (Guttmann, 1996; p. 86).

However, to be able to "*forget*" about oneself, one must give of him-, or herself. This applies not only in the treatment of sexual dysfunctions treated with de-reflection, but also to other human achievements, where through de-reflection, we are invited to "empty ourselves" for the sake of something, or someone else (Frankl, 1994, p. 81).

Guttmann (1996) explained the difference between paradoxical intention and de-reflection the following way: Through paradoxical intention, one is invited to engage in '*right passivity*' by distancing from the symptoms and ridiculing them. Through de-reflection, however, one is invited to engage in the '**right activity**' by immersing into a meaningful task.

Examples of de-reflection can be found in most of Frankl, and Lukas's books. It is typically used in situations that involve anxiety, coupled with hyper-intention and hyper-reflection, which was classically employed in the treatment of **insomnia**, and **sexual disturbances** (Frankl, 1986; Lukas, 1998). It has also been reportedly used in the treatment of a variety of conditions, including "fear of choking," social isolation (Frankl, 1986), and hysteria (Lukas, 1998).

Dr. Lukas (1981) expanded the application of this technique for use in the case of **addictions**, **psychosomatic disorders**, and various cases in the medical setting, where she used de-reflection in individual and group therapy (Lukas, 1986).

Other publications on the use of this method include: The use of de-reflection in the treatment of **recovering alcoholics** (Crumbaugh, Wood, & Wood, 1980; Henrion, 1987; Haines, 1997), and the use of de-reflection in the treatment of **chronic pain** (Kahatami, 1987; 1995); and **burnout** (Bulka, 1984).

Since de-reflection is a non-specific technique, it can be very well combined with other approaches to therapy. Several such case examples are presented in the articles of the *International Forum for Logotherapy*. Especially helpful for the clinician, are those articles that relate to the use of de-reflection in the treatment of disorders classified in the DSM-IV (1994) manual.

A special example of the use of de-reflection with the **families of schizophrenic patients** was presented by Dr. Lantz (1982), in which article he details those typical patterns of interaction that have been characteristically associated with predisposing for further relapses in the patients. Dr. Lantz notes that "…*the most practical method to decrease hyperrreflection and hyperintention is to help clients direct their attention to something else*." He found three methods of de-reflection to be particularly useful in helping families of patients with schizophrenia to think about subjects other than the patient: (1) Teaching the family about the chemistry of schizophrenia; (2) challenging the family role as 'psychotherapist;' and (3) helping the family develop non schizophrenic-connected interests and activities (Lantz, 1982; p. 120).

On the basis of the above examples, we can reconstruct the general process of de-reflection:

1. **Ascertain about the roots of the hyper-reflection and hyper-intention;**
2. **Explain the connection between hyper-intention, and hyper-reflection and current symptom formation;**
3. **Direct patients awareness towards positive aspects;**
4. **Generate an "alternate list" of meaningful activities;**
5. **Help patients to refer to their alternate list, whenever they notice that they are hyper-reflecting, or hyper-intending.**

The first step in the application of de-reflection is to ascertain whether the root of hyper-intention and hyper-attention is a medical illness, which has to be treated separately. If it is possible to see a connection between the hyper-intention and the illness, the therapist can point this out to the patients, along with the hyper-attention, which causes extra amount of suffering. The same is the case when there is no known physical illness behind the symptoms of hyper-intention, and the vicious cycle has roots elsewhere--de-reflection can be suggested as one possible way of breaking this pattern.

According to Frankl (1986; p. 258), de-reflection can only be attained to the degree to which the patient's awareness is directed toward positive aspects:

> "The patient must be de-reflected **from** his disturbance *to* the task at hand or the partner involved. He must be re-oriented toward his specific vocation and mission in life. In other words, he must be confronted with the logos of his existence! It is not the neurotic's **self-concern,** whether pity or contempt, which breaks the vicious circle; the cue to cure is **self-commitment**.*"*

Subsequently, therapists may invite patients to ponder, or even to compile an "**alternate list**" (Lukas, 1980; p. 26) with various helpful thoughts, attitudes, or activities that they think would enrich their lives. They are asked to think of circumstances in which they would start to hyper-reflect, and when they think that they could try out one of their alternate activities. They are encouraged to engage in these activities.

Regarding the application of de-reflection in clinical practice, Lukas (1980) remarked that once patients decide which alternatives work best for them, they are on their way to symptom reduction: Instead of being trapped by self-fulfilling prophecies, they are concerned with accomplishing self-selected meaningful tasks. According to Guttmann (1996; p. 94), in this process, they gradually gain "…*a new self image of a free person*."

It is not easy to get a person not to think about a troubling problem. Therefore, the proper application of technique requires experience, and creative improvisation by the therapist. "…*It is worth the effort because it contains the key to the human spirit where the will to meaning can overcome the will to satisfy needs*" (Lukas, 1986; p. 49).

CASE EXAMPLES:

Case 1: Sexual Difficulties.

> A young woman came to see Frankl, complaining of being frigid. Her case history indicated that she was sexually abused by her father when she was a child. It turned out, however, that her complaints were due to her reading psychoanalytical literature, which resulted in the fearful expectation of the toll of her traumatic experience would cost her some day. Her anticipatory anxiety led her to pay excessive attention to her own behaviour and to hyper-intention to confirm her femininity. The result was an incapacitation for a satisfying sexual relationship, which she so desired, and that she made an object of her intentions. In short-term logotherapy, relying mainly on the use of de-reflection, her attention was re-focused toward her partner, and she reported that her previous concern disappeared (Frankl, 1962; p. 123; cited in Fabry, 1994; p. 142).

Case 2: Reactive Depression.

> "When I met Mrs. B., she was a 62 years old lady with a background in music, theatre, and arts in general. She was also sick with cancer and had a 'bad prognosis.' Nevertheless, she was cheerful and full of vitality—until a follow-up medical examination resulted in a verdict of 'terminal illness.' From that time on, all she could think about was her pain and impending death. She became withdrawn, and apathetic. Her talk, which formerly encompassed most everything under the sun, concentrated on one thing only: her pain and fear of death. I used de-reflection. This is, I alternated the questions about the current condition with questions about her former hopes, interests, aspirations, and relationships. Thus I learned about her secret wish to have her drawings and paintings exhibited in public. She responded well to the suggestion to begin working on that wish to become reality. The new interest gave her a sense of hope and meaning which were translated into action. She worked hard and had a very successful exhibit, which gave her a new self-image and renewed interest in life" (Guttmann, 1996; p. 101).

Case 3: Suicidal Feelings.

> "Mrs K. was a 75 year old woman, living in Israel at the eleventh floor of a housing facility for the elderly. Her husband died three years ago and she had no relatives. I met her sitting on the open window's edge, with one foot dangling out in the air:
>
> She took pleasure in frightening other people watching her sitting there and playing with death. She would also chase away those who dared to come near her, yelling: 'Mind your own business!' But she seemed favourably inclined toward my presence. Even though I was afraid that she might jump, or fall off the window, I pretended not to notice the dangerous pose and invited her to talk about herself. But I also made one condition, namely, that she would get off from her perch and sit with me like a lady should. The word 'lady' evidently made a change in her behaviour. She broke down, and with tears she told me about her former life, her losses, and constant preoccupation with death. Her hyper-reflection on death had to be broken, or she would commit suicide, I thought. Thus, I used Frankl's de-reflection. I said: 'I know that you don't intend to jump off the window, for you could do so any time. You only wish to show that you are not afraid of death. But there is plenty of time for you to die. Who knows, you may even live up to a hundred and twenty, like Moses, so why do you wish to idle away your life?' She seemed hesitant for a moment and asked: 'So what should I do?' The ice broken, we worked out a plan for Mrs. K. to help in the office with the running of the tenants' newsletter, a job she really liked. And sitting in the open window became a thing she wanted very much to forget" (Guttmann, 1996; p. 101).

(3) Modification of Attitudes:

Logotherapy's **Modification of Atittudes**, is a technique specifically applicable for the treatment of **noogenic neuroses**. As we mentioned in the previous chapters, noogenic neuroses can arise in situations where there seems to be a loss of values, or value conflicts, or conflicts of conscience.

Such conflicts almost always arise in the case of **situations that can not be changed**. In other words, tragedies, misfortunes, accidents, or strokes of fate, which do not make sense, and not meaningful in themselves.

The essence of the modification of attitudes techniques lies in the recognition that, even though some situations can not be changed, and seem to be meaningless, there is **meaning in every situation**, which is potentially available to be salvaged by people in how they respond to tragedies.

In response to limitations, or tragedies it is easy to assume an attitude of resignation, or hopelessness.

In fact, we have seen that there are typical unhealthy attitudes with which people may respond to obstacles, difficulties, or seemingly senseless events in life: They may resort to collectivistic, fatalistic, fanatic, or provisory modes of existence, which are often suggested as ways of coping by society; or, begin to harbour resentments, and excessively fight-, force-, intend-, reflect-, or flee from that which challenges their previous ways of perceiving sense, and meaning in life. The result of these efforts are often doubt, and despair.

People who are in **doubt**, said Lukas (1986), can be characterised as individuals who are still searching for meaning, but they see none at the moment. People who are in **despair** are individuals who once possessed a healthy meaning orientation, but they lost it through a blow of fate, or who got tired of their lifestyles and became disappointed with themselves, and the world around them.

Many people who are "desperate" appear "successful" to the observer from the outside. However, they are prone to a "narrowing of their vision" to the one or two values which they "**absolutize**," gradually loosing their ability to perceive the entirety of the world and its events (Wolicki, 1987). They loose contact with the world in terms of the ongoing suffering, acts of mercy; opportunities for thankfulness, gratitude, or appreciation. These reactions are normal in response to traumatic events. However, if they persist, they create an increased risk for emotional disorders, i.e., leading to Adjustment Disorders, or Posttraumatic Stress Disorder.

A case of a person in despair was illustrated in the following example:

> "Mr. A., age 60, spent 40 years of his life as a librarian in a scientific library. When he was told that according to the law, he had to retire, he panicked. He claimed that 'he would simply die,' rather than retire. 'My life is empty without my job,' he told his confidant. 'I don't know what to do, or how I would survive this blow of fate.' As the day of retirement was nearing, he became more and more depressed, or alternatively, quarrelsome, and confused, and was seen being tortured by doubts of his ability to survive in the changed circumstances of his life" (Guttmann, 1996; p. 122).

As we see from the above example, Mr. A has a so called "**pyramidal value-system**" (Lukas, 1996). This value-system got its name from the hierarchical, pyramidal, way in which values are represented in it: there are more values that are acknowledged, a few that are esteemed, and, at the top, one particular value which is idealised.

The problem with the pyramidal value system is that it makes us very vulnerable to depression [Noogenic neurosis, and depression] when this value is threatened, or, we can not live up to it, or it is no longer possible to live up to it for some reason.

A healthier attitude is to build a "**parallel value system**" (Lukas, 1996) in which there are a few values, four, five, or more, instead of one, which we consider important, so that we can be more flexible, and have a richer perspective on what we can do when one value is lost, or we are unable to live up to it.

An example that Dr. Lukas (1996) used to illustrate the parallel value system was from Frankl's life when his health deteriorated to the point that he could no longer work and teach. He continued to receive his students, dictate his writings, and devote himself to spending time with his family.

However, what happens in the case of facing tragedies and suffering in life, in general? How does logotherapy's M*odification of Attitudes* apply in the case of unavoidable suffering, which causes real pain?

In the book *Logotherapie und Existenzanalyse* ("Logotherapy and Existential Analysis"), Frankl (1994; pp. 130-146) summarised logotherapy's considerations that apply to suffering under the title "*Metaclinical Pathodizee:*"

> Logotherapy recognizes that, in general, there are three tragic aspects which affect us: We are all confronted with the ending of our lives, death; pain, at some point, and in various ways; and guilt, as an existential fact. Some of this is avoidable, but some is not possible to change.
>
> Logotherapy advocates that whenever it is possible to avoid unnecessary suffering, it should be avoided, or alleviated. There is no meaning in wallowing in useless, avoidable suffering. To do so is masochism, rather than achievement (Frankl, 1965).
>
> On the other hand, to the suffering which we can not control, foresee, or avoid, Frankl coined the term the "**Tragic Triad of Human Existence**," to which belong **pain, guilt**, and **death** (Frankl, 1967; p. 92). Pain refers to the reality of human *suffering*, guilt to the awareness of our **fallibility**, and death, to the awareness of our own mortality.

Dr. Frankl (1965) emphasized that the contents of the "**Tragic Triad"** are not subject to repression, and they do not represent the instinctual aspect of our being. On the contrary, when we are aware of them, pain, guilt, and death can make us more perceptive of our **spiritual aspirations**. Frankl (1967) maintained that in our society, neuroses are more likely to originate from an attempt to obscure the reality of pain, guilt, and death as existential facts, than from repressed sexual impulses, which might have been the case in earlier centuries. Therefore, he stressed that pain, guilt, and death should never be explained away, but rather their reality **acknowledged** and faced in therapy (Frankl, 1967).

There are numerous book sand articles that deal with the topic of logotherapy's response to suffering, such as: Atlas (1984); Barnes (1993); Berti, & Schneider-Berti (1994); Eisenberg (1982); Frankl (1986b, 2000); Haines (2000); Kovacs (1982); Lukas (1986, 1990); Shantall (1998); Sternig (1984).

Here we will consider the use of M*odification of Attitudes* in general with regard to the *Tragic Triad*:

Modification of Attitudes begins with the recognition that our attitudes are not determined by the situation, but by us. Its aim is to draw our attention to the fact that **meaning is available in every situation** (Lukas, 1980).

Subsequently, the goal of the therapist is to use knowledge and intuition in assessing whether a certain attitude by patients is harmful, or not. When the therapist discovers destructive or unhealthy attitudes, he or she does not judge them as good or bad, but brings them to the open to discuss them, and to weigh if they are healthy or not , in the light of the search for a meaning-oriented life.

The task of the therapist is to **change the dialogue with oneself**, and the reflection on the world, in a way that it comes from the patient, and reflects the truth and reality recognised in the patient's inner self.

Thus, a sketch of the process of modification of attitudes is as follows:

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

The logotherapeutic wisdom which helps therapists change unhealthy attitudes comes from the principles of **logotheory**, which we presented in the first few chapters. They are also described in many writings, especially, Frankl's *Unheard Cry for Meaning* [1978; "Temporality and Mortality: An Ontological Essay," pp. 115-128]; *Man's Search for Meaning* [1984; "The Case for Tragic Optimism;" pp. 139-154]; *The Doctor and The Soul* [1986; "The Meaning of Life," pp. 26-62; "The Meaning of Death" pp. 63-92; On the Meaning of Suffering," pp. 105-116] and *Unconscious God* [1975].

Some of this wisdom, which can be helpful for therapists to find a meaning-oriented attitude includes that nothing that is in the past is lost. On the contrary, everything is irrevocable stored: "*Everything in the past is saved from being transitory*. *Therein it is irrevocably stored rather than irrevocably lost. Having been is still a form of being, perhaps, even its most secure form*" (Frankl, 1967; pp. 30-31).

What we accomplish in a life-time remains saved, just like good harvest that is collected into the granaries. It remains stored for eternity. *What we experience, nobody and nothing can take away from us*, nobody can rob us from it, or annihilate it (Frankl, 1978).

Life in body and mind is transitory, and finite. However, exactly this transitoriness and finiteness ands to life's meaningfulness (Frankl, 1967). Life's quality can far surpass its brevity (Barnes, 1993).

The human spirit can never be destroyed, and it lives forever, even when it can not express itself through its instruments [of body and mind; Barnes, 1993].

The strength from the "**defiant power of the human spirit**" (Frankl, 1984; p. 147) can be activated to help patients to find ways in which they can act "**despite**" difficulties, "**even though**" they may not yet see the way forward, and "*still*" when the going gets tough.

Other times, logotherapsists invite to act "**as if**" the strength was already there, recognizing that every day offers new possibilities, and we can use the time to mould ourselves, or to sit in patience, until the situation changes, or meaning becomes visible.

The attitude of **gratitude** (Coetzer, 1992; Schulenberg, 2001) about what was, and what can still be, is also a way of engendering **attitudinal values**, which help patients to grow and to gain strength and trust in facing obstacles.

> "There is no need to dwell on the past forever. A delicate balance must be found between past accomplishments and the promise of the future. Love experienced, however important and significant at the time; work accomplished and treasured; deeds performed in the service of the community, or persons in need, must be put in proper perspective. They are the realities of the past; they are treasured for what they meant, people can turn to them for solace and hope. Yet, life demands living in the present. The past is safe, for it cannot be taken away, whereas all else can be lost in an instant; we have to concentrate our waning energies on the present—but with an eye on the future, even if this future may be short-lived. For only in the present can we correct past mistakes, repent past wrongdoings, atone for past sins, and mend our ways (Guttmann, 1996; p. 22).

Logotherapy's *Modification of Attitudes* offers a compassionate and caring approach to patients' current life situations, and to their worries: Often times, we see that worries and anxieties are not intentionally "unhealthy." Rather, they represent a persons' authentic concern about the meaningfulness of existence, and thus in its smallest personal facets. By **acknowledging** such **existential concerns**, the therapist's task is to confirm that meaning is available in every situation. By engendering **faith, hope**, and **love** in *Ultimate Meaning*, modification of attitudes can be specifically used to encourage-, exhort-, embrace-, comfort-, console-, and to help patients re-gain their inner balance by finding a self-transcendent attitude, and thus regain their inner peace, knowing that they are awaited by-, and cared for, from the "greatest" to the "smallest" details of their existence.

> In the case of "Mr. A.," for example, the therapist would acknowledge his apprehension regarding the retirement, especially for the reason that Mr. A had been an exemplary and conscientious employee, to the point where he did not develop hobbies or interests aside from his work. Obviously, his impending retirement easily plunges him into a crisis. Here is where there are limitations, but also strengths: Mr. A is desperate exactly because he is a conscientious human being, who found immense amount of meaning in his life as the employee of the scientific library. He is now afraid that everything has come to an end. However, a logotherapeutic dialogue may help him to see that "In the past everything is irrevocably stored"—Mr. A. can take stock of his contribution of the work he did for the library, and to see that he has used his skills and talents to his best ability. This is what irrevocably remains after him in this life. Considering that he still has a long life in front of him, the challenge is to find areas in which his skills may be much needed, or where he may be irreplaceable, such as in other forms of scientific work, or relationships. There may be other beautiful experiences in the world, which wait for him to be discovered and savoured, which now he may have the opportunity to enjoy. Life can be still full of exciting things to discover.

As we mentioned earlier, *Modification of Attitudes* is a **non-specific** logotherapeutic technique, and, therefore, its applications are very widespread: For example, Mendez and Mendez (2003) highlighted the use of *Modification of Attitudes* as early as in the process of obtaining consent for treatment. In the therapy phase *Modification of Attitudes* can be used not only in helping patients face unalterable, or difficult situations, and **existential concerns**, but also for highlighting their own strengths and wisdom (i.e., Abrami, 1997), and orienting them toward concrete personally meaningful goals. While it is very easily combined with other approaches, it complements treatment with a touch of truth, and grace.

CASE EXAMPLES:

Case 1: Attitudes About Signs of Ageing.

> "Mrs. H. was 29 but she started to dye her hair since she discovered her first grey hair at the age of 25. She had developed a strong allergy against the dye and was in danger of losing her hair if she continued to dye it. She became so desperate that she considered suicide. I attempted modulation of attitudes and drew her attention to the fact that grey hair can be seen as a warning signal: time is passing. Stop postponing. Usually, the warning signal comes at a later age, but having received it at 25 it gave her more time to do things.
>
> She began to see her grey hair with new eyes: not as a reminder of her aging, but of the things she still wanted to do. She started rug weaving, a hobby she postponed, she travelled, and took courses. She considered her aging as an impulse to living, and she did not think of death any more" (Lukas, 1979; p. 7).

Case 2: Attitudes About Past Failures.

> A woman came to see Guttmann (1996) in despair because she could not get over her fear of failing the university examination. She reported that every time she started to study, she remembered her high school teacher who told her that she would "never succeed." She accepted this statement without criticism and even before taking the exam, already considered herself a failure.
>
> In order to awaken her defiant power of the human spirit, the therapist challenged her to see that "…you are not a failure, unless you want to become a failure" (Guttmann, 1996; p. 127). He told her that many predictions are made by people that turn out to be mistakes. He invited her to prove to herself and to her former teacher that the teacher's predictions were also mistaken. "People change and are able to change" (Guttmann, 1996; p. 128), he aid to her.

When he inquired about whether it was possible that, at the time that the teacher made this prediction about her future, she was really not doing her work diligently, she acknowledged it with a smile on her face. She recalled that she was preoccupied with thoughts and fantasies about a boy and neglected her studies. “But now,” she said, “I feel I am ready to try” (Guttmann, 1996; p. 128). The therapist reported that she left the office determined to prove to herself that she can do her best this time.

Case 3: Attitudes About a Divorce.

“My patient was a man whose much younger wife had left him and an infant and was unwilling to return. She let him know that he was too old for her and she wanted a divorce. The man was devastated, developed a heart condition, and looked as if he would not live long. It seemed impossible to find a goal that would give his life new meaning. Wife and child had been the entire content of his life, his sorrow sapped his strength. He could not think of anything else. It was necessary, therefore, to link suffering itself with some meaning he could accept. His choices were limited because he could not do anything to win his wife back. I offered him another, imaginary choice: ‘When two people promise each other to stay together under all circumstances, and one of them breaks the promise and leaves, then the one who leaves presumably feels pleasure, and the other must suffer. But the one who is left is guilty of a broken promise, while the other has a clear conscience. If you had the choice, what would you have chosen: suffering and clear conscience, or pleasure and guilt?’

He decided in favour of his own role, the role of the one left behind. He said that if one of the partners had to suffer, he was prepared to be the one, that his suffering did not seem completely meaningless if it was the price for keeping his promise. This was the beginning: accepting fate and bearing his loneliness with courage” (Lukas, 1986; pp. 26-27).

Case 4: Attitudes About Accepting a Child with Down’s Syndrome.

“One of my doctor friends, a religious man, has five children, the last child was born with Down’s Syndrome. He was shocked to realize that all his medical knowledge was not sufficient to cure the child. But he found a meaningful response: ‘My wife and I try to imagine how God, as He deliberated to whom to send this handicapped child, decided on us a us as a family because He trusted in our strength to give this child as much love and protection as he needed. We are thankful for this trust and will try to show ourselves worthy of it” (Lukas, 1986; p. 147).

Case 5: Attitudes about Facing a Tragedy.

"In February, 1992, a family came to my office whose little girl had been killed one day before her fourth birthday. I knew the circumstances they were coming to talk to me about, and I thanked God for the experiences in my life that prepared me to help this family. The grief stricken mother, father, and a 13 year old brother told me about that tragic day. A neighbour lady had stooped by on her way to the grocery store to see if Mrs. Smith needed anything, "Let me go with you,' Mrs. Smith said. 'Sally's fourth birthday is tomorrow, and I need to get some things so I can bake a birthday cake for her.' While Mrs. Smith was getting her purse, Sally ran outdoors so she could go too. Unfortunately, the neighbour lady had left the engine of her car running. In a flash, little Sally had jumped into the car, pulled the gear shift into reverse, and was thrown out of the open door as the car began to back up. Almost hysterically Mrs. Smith told the story. 'When I came out of the house, the car was backing round and round over my precious little girl's body. I screamed and ran to her,' Sally's mother said. 'I scooped her up in my arms. Blood was coming out of everywhere--her ears, her nose, her mouth. She couldn't talk, but she was still breathing. Her eyes were looking right into mine.' Sobbing in my office, little Sally's mother said, 'I can't get that sight out of my mind, Dr. Barnes. I can't even go to sleep at night. I just keep seeing all that blood, and I see her eyes looking into mine. Then she died. Why did I have to be the one, why did I have to see my child bleeding and dying and not able to speak? Why me?'

> I took Mrs. Smith's hand into mine and said, 'I am sorry for your pain. Truly, I am. I'm sorry for the loss of your precious child. I am sorry it was you who had to see that blood and live with that memory. And yet, I am so thankful it was you who held Sally in the last moments of her life. She had come through you, and before she returned to her heavenly father, she knew she was in her mother's arms. She could no longer speak, but she could see. I'm so glad it wasn't a stranger who held her as she drew her last breaths. I'm so glad she knew she was in the arms of her mother.'
>
> 'Oh, Dr. Barnes,' Sally's mother said. "I hadn't thought of it that way. I'm glad it wasn't a stranger who found her and held her as she died. I'm thankful I could be the one. Seeing it this way, I can live with my memory now"‘ (Barnes, 1993; pp. 20-21).

POINTS TO PONDER:

* In which situations can you imagine *paradoxical intention* most successful? Can you think of examples from your life when you intuitively applied this technique?

* How about *de-reflection*?

* Have you ever found that the *modification of your attitudes* helped you to regain your inner peace?

Chapter VIII: Narrative Logotherapy

In the article "*Key Words as a Guarantee Against the Imposition of Values*" Dr. Elisabeth Lukas (1999; p. 1), mentions that logotherapy is a value-oriented accompaniment in all aspects of life:

> "Proof to this is the fact that it can be applied in the treatment of a variety of difficulties, including anxiety syndromes, affective disturbances, addictions, sexual aberrations, and personality, and behaviour disturbances. It can support young people in their search for themselves, or their efforts to reach maturity, or help the elderly to look back on their lives and to prepare for their death. It can be used in individual therapy, in group therapy, and with families to help resolve conflicts, and help working people and the unemployed cope with the demands placed on them, whether too much, or too little. It can even provide care to those burdened by their everyday sorrows, and resentments, and guide those who have lost hope back to their spiritual home."

Yet, logotherapy's main medium is **language**.

Narrative logotherapy explains how through listening, and careful reflection, therapists can recognize and aid their patients' will to finding meaning, and guide them toward areas in which meanings can be found.

There are several "*core-skills*" which help logotherapists accomplish this goal, which are embedded in the therapeutic dialogue.

According to Lukas (2000), they are: (1) **The Use of "Key Words**;" (2) **Careful Differentiation**; (3) **Naïve Questioning**; (4) **The Use of Symbols and Metaphors**; (5) **Illustrating Meaning Possibilities**; and (6) **The Socratic Dialogue**.

(1) Key Words:

This skill requires careful listening to patients' words. It rests on the principle that our conscience is a *meaning-organ*, which guides us reliably to what is meaningful, and points to the direction of meaning, without the therapist having to impose, or invent meaning.

Conscience also points to an inner point of reference, and inner standard, which is rooted very deeply within ourselves, and with which guidelines we can adapt arguments, and follow principles that allow for the change and correction of behavioural patterns, or modification of attitudes, in a way that, rather than becoming an imposition, we follow signals from our inner self.

Careful listening to the words of the patients allows to discern the "**signals**" and "**clues**" of their depths, and the heights to which they aspire, and to hear what the spiritual person intends, beyond the cognitive meaning of the words.

According to Lukas, in listening to *key words*, the therapist looks for clues about **interests**, **concerns**, which emerge through the **themes** and **topics**.

To capture the *key words* requires **empathetic listening**, and summarizing what is being said by the patient. It requires **presence** from the therapist, attention, and concentration. It also requires **intuition**, and sharpening one's eyes to key concepts which emerge from the dialogue.

The following case example by Dr. Lukas (1999) illustrates how the perception of *key words* allows to notice nuances and shades in what patients mean, and to infer what they find meaningful:

Case 1: Search for Meaning.

> A woman, around 30, had a thorough organic check-up because she felt moody and apathetic. When the doctor told her that the examination showed her to be in perfect physical health, she reacted unexpectedly. If she was healthy and no one could help her, she burst out that she might as well commit suicide. The doctor sent her to our counselling centre.
>
> The woman could not give any reason for her negative attitude. "I'm well off," she said, "but I don't enjoy living.' 'Were you always well off?' I asked. She thought for a while, then told me that she had to interrupt high school when her parents divorced, found minor employment, but was ambitious, and worked in evening classes to attain a high school diploma. She entered the civil service, worked conscientiously, and reached the highest level available, tenure, with full pension.
>
> 'Was this time when your apathy began?' I asked. She admitted that this could be so. 'Then, I think I know what you need,' I ventured. 'You need a goal. All your life you have been ambitious, and now suddenly you've reached your goal and cannot advance. But you have too much mental energy to stand still, you need new challenges, new areas of activity. To be well off is not enough, standing still does not satisfy human nature.' The woman had listened attentively and was no longer uninterested. 'You are right,' she said. 'What I need is a goal. Now that you've said it, I know it is true. And here I thought you will analyze my entire childhood and trace my difficulties back to the divorce of my parents…' We both laughed, and the ice was broken." (Lukas, 1986; p.71).I

The following example illustrates that *key words* can be used to re-capture the essence of a session and the key message of a dialogue. This will accompany patients in a comforting way when they have to face their difficulties in a new way:

Case 2: Facing Fear.

> A religious woman had reportedly developed unexplained, panic-type fear that her husband, for some reason, one day may not come home to her after work. After a conversation which highlighted her fears, the therapist and the woman came up with this comforting key formulation, which she started to repeat for herself whenever she started to feel anxious: "*Either he will come home to me, or he will go home to God. In either case, he will be safe.*" This formulation helped her to live with her fear, and even see it in a different light (Lukas, 2000).

(2) Careful Differentiation:

In the therapeutic dialogue, it is essential that therapists learn to bee **accurate listeners,** who can summarize what they heard from the patients, and structure their questions so that they are able to distinguish carefully what is meant, with its implications, advantages, or disadvantages.

According to Dr. Lukas, reality has many shades, and a key to resolving conflicts is to distinguish as many **shades** and **fine lines** as possible. The more **nuances** one can see, the better off one is in therapy (Lukas, 2000).

Issues can be looked at from different **perspectives**, from several vantage points, and the therapist has to pay attention to, and ward off **overgeneralisations,** which can be questioned: "*Is this really so?*"

As well as therapists aim to distinguish what one **actually** said, and the **interpretations** of it; what **actually** happened, and one's **interpretations** of it; **compare** and **contrast expectations**, and **facts** in reality:

Case 3: Establishing Facts.

(Part of a Dialogue with a Student)

"**She:** I go through such depression, I can't enjoy life.
I: Do you have reasons for the depression?
She: My grades are poor.
I: Can you improve them?
She: Yes, I'd have to study harder.
I: Why don't you?
She: I don't feel like it.
I: Who or what is at fault for your unhappiness?
She: The poor grades.
I: No.
She: That I don't study enough?
I: No.
She: That I don't feel like studying?
I: Not that either.
She: What then?
I: That you make the amount of study, which you yourself consider meaningful and necessary, dependent on your moods" (Lukas, 1986; p. 122).

Case 4: Taking Perspectives.

A middle-aged schoolteacher complained of experiencing symptoms of depression, especially after a difficult day at work. She mentioned that even her relationship with her husband had suffered as she felt no connection with him after long hours of work, and she rejected his attempts to caress her, which he usually liked to do in the evenings when he also arrived home from work. As a result, she reported feeling distant from her husband and wanted to separate from him so that "he would leave her alone." After asking her to put herself into her husband's shoes and to report what is usually happening after work, the woman suddenly gained a new insight. She recalled that her husband was an immigrant to the country before they got married, and how much it had meant for him that they could be together, and that she had a good profession. Through talking about her husband, and his ways of expressing his affection to her, she realized that her husband needed her, and appreciated her, and thought that she was still beautiful and lovable. With this insight in mind, she reported that, even though not all of her previous complaints have disappeared, she resolved that she loved her husband, and wanted to remain a good and supportive wife to him. From then on, she reported no concerns about their intimacy. She also went on to report, that from then on, each time she thought of something that her husband had done that she found upsetting, she tried to think of her husband by putting herself in his shoes. This method helped her to avoid to make quick judgements, and understand, and respond to her husband with love.

(3) Naïve Questioning:

Naïve questioning is a form of questioning in the dialogue which is used when patients are filled with **anxieties, insecurities**, and, sometimes, with **self-pity**, or they are influenced by someone else's ideas, to the point that they **loose their independent thinking**. The therapist, by the way of asking *naïve questions*, leads patients to see that their attitudes, or adopted way of thinking, is unhealthy, or even dangerous, and leads them to question their original stand, and clarify where they really think.

This is done by the therapist seemingly accepting the patients' attitude, and temporarily placing themselves in the **patients' frame of reference**. The questions are formulated so that patients feel seemingly affirmed in their unhealthy attitudes, which may be surprising to them. Then, the therapist follows with counter-questions, which may make patients feel confused, so that they have to clarify to themselves where they stand with respect to their "stuck" attitude (Lukas, 1986; p. 98).

According to Dr. Lukas (2000) the advantage of this questioning is that patients' **resistance** to the therapist can be turned into an external **dialogue** with themselves, about the topic which caused them to have uneasy feelings toward themselves, the therapist, or their situation.

Case 5: Resolving Unreasonable Guilt.

Mrs. X.: I also feel a lot of guilt about my daughter.
E.L.: What do you mean?
Mrs. X.: For instance, she often has bronchitis because I always kept her warm when she was small.
E.L.: But Mrs. X. that's no reason for guilt!
Mrs. X.: (resistance based on a fixated, unhealthy attitude):
Oh, yes, it's my fault, the girl is not used to cold and gets sick easily. I've never been a good mother….
(By means of naïve questioning an attempt is made to redirect her resistance to the therapist to resistance against her baseless feeling of guilt.)
E.L.: You always dressed your daughter warmly in the winter?
Mrs. X.: Yes, I did.
E.L.: (naïve) So, you wanted her to get a bronchitis?
Mrs. X.: No. no. I didn't want that!
E.L.: You did not want her to become sick? What *did* you want?
Mrs. X.: I wanted her to be healthy, that's why I dressed her warmly.
E.L.: (counter-questioning) Suppose you had been careless in dressing your daughter, without shawl and cap in the winter, and with sandals and no socks in February. And later she came down with bronchitis because she had that predisposition. Then you would have never given it a thought that it might be your fault.
Mrs. X.: (perplexed) I don't know. Perhaps I also would have felt guilty because I didn't dress her warmly enough, Yes, I think…without a shawl and a cap, I would have blamed myself.
E.L.: (naïve) Then, it's your fault in any case?
Mrs. X.: Well, you never know what is best, do you?
E.L.: (naïve) But if you do what you think is best, you still have to blame yourself?
Mrs. X.: No. If a person does her best she cannot blame herself.
E.L. (normal): Right Mrs. X., our fault is measured by intentions. You actually are to blame for all the sickness you *wished* on your child.
Mrs. X.: Then, my fault isn't very great. I never wished sickness on anybody.
E.L.: Then we agree that the bronchitis can't be blamed on you but on fate as sicknesses usually are?
Mrs. X.: Yes, that's true. That makes me feel better… (Lukas, 1986; pp. 98-99).

Case 6: Resolving Ambivalence.

> Maria, a guest worker form Sicily, was a widow with a small child, who was offered a job in Munich at a Pizzeria, which she accepted. The move to Munich from Sicily meant that she had to leave behind her son, and to entrust him to the care of her relatives. Initially, she was enthusiastic about this opportunity, as she had no job in Sicily. However, soon after arriving to Munich, she stared to doubt the wisdom of her original decision, and instead of working, she spent the time at home, crying and questioning of what she should do?
>
> Instead of advising her what to do, the therapist asked her questions that would hopefully clarify what she thought was wise: "What actually caused you to choose the pizzeria in Munich?" The woman explained that there was severe unemployment in Sicily, and that she was motivated by the possibility for earning enough money for her son to get the best possible education to find work later. The therapist then asked her what she would be able to do for her son if she was to return to Sicily? The woman replied: "Not much. Apart form my presence I can not offer him too much." The therapist questioned this possibility as well: "But, isn't your presence very precious to the child, too?" Whereupon Maria replied: "Yes, but it can be replaced, because my son is very well taken care of by my mother, he is very close to the grandparents, aunts, and cousins."
>
> This dialogue helped to clarify that Maria believed that it was better for her to stay in Munich. In the light of her love for her son, her sacrifice gained meaning, as everything she did, all the money earned was done with her son in mind. Through the dialogue, it became clear to her that, as a mother who truly loved her son, she chose to accept the hardship so that her son could have a better life (Lukas, 1999; pp. 2-3).

(4) Use of Symbols and Metaphors:

The use of similes, analogies, symbols, and metaphors is widely used in logotherapy because they are easily retained, and they can be easily recalled and used in similar situations. Role-playing, and dramatisation helps patients to gain distance, and reinforce their confidence in their own philosophical abilities and relatedness to others.

For example, in the case of anxiety, one can externalise anxiety by giving it a name: Mr. Anxiety, and imagine it, draw it, or talk about him: "*Here he is again. Are we going to allow him to come in for a while, or shall we tell him that he needs to wait in the waiting area today? How is he doing today? Has he changed any since yesterday?*"

Analogies also help to differentiate, and to advance from what is **concrete**, to what is **abstract**, and back to the concrete.

In using the "**visible metaphor**" (Moore, 1998; Moore, 2002), one can rely on everyday objects, plants or animals for making comparisons, and utilising patients imaginary resources. What is relevant is to choose a metaphor that is meaningful to patients (preferably they come up with it), simple, and salient for them. The therapist and the patient can stay with this image as long as they want to, allowing new insights to emerge.

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

Poignant metaphors are available from nature, art, music, or even the sciences; physics, chemistry, and technology. For example, Dr. Lukas (1994; pp. 81-93) devised a very thoughtful "**candle-meditation**," which can be used to guide reflection of the transitoriness of life. In this metaphor, the wax and the wick stand for the person's body and mind, respectively. The light represents what we give to the world.

As the candle looses the amount of wax available, so is time limited in life. Our life may be burdened by illness. However, a "*broken candle*" can still give light. And, "*long after a candle's light has been blown out, its warmth remains*." –These and similar metaphors enrich the therapeutic dialogue, and bring transcendent, abstracts truths closer to home in patients' hearts.

Case 7: Ameliorating the Meaning-Crisis in Geriatric Depression.

> Dr. Pintos reported the following dialogue with Ada, a former concert pianist; an elderly lady, who was suffering from severe depression, muscular degeneration, disorientation, and was in a severe confused state. She was nearly blind, and was in a lot of pain. The therapy sessions started after she had taken an overdose of medications in an attempt to commit suicide. The therapist worked with her, and her caregivers, for a long time, and in the course of regular contact with her over several months, came to recognize her love for music, when the following dialogue took place:
>
> "One day, Ada was waiting for me in the living room. That was the only time during her treatment that we met in a place which was not her own room. 'Vladimir,' her piano, was in the living-room. Ada gesticulated as never before when she spoke, even sat up to dramatise situations, within her possibilities. In that interview, the topic of music appeared again. She talked about the difference between a composition ending 'in crescendo' and one ending 'in diminuendo.' After her explanation I involved her in the following dialogue:
>
> **ME:** What makes a piece end one way or another?
> **ADA:** Well…it depends on the content of the play and the composer's will.
> **ME:** It means each composer, you for example, decides whether his piece will finish with a glorious chord or not?
> **ADA:** Sure…as you say…if it finishes with crescendo, it finishes with a glorious chord…
> **ME:** Almost as it happens with our own life, doesn't it?
> **ADA:** …
> **ME:** One decides whether one's life will finish in diminuendo or in crescendo, whether one will leave this world 'without sorrow nor glory' or finish it with all one's power…with glory…
> **ADA:** …You are right…it's like that…
> **ME:** I believe the life of an artist can't finish both in crescendo, because the artist is the one who can always find, compose, invent, or create an answer to his life…
> **ADA:** …Yes…it should be like that…
> **ME:** Truly…it should be like that…

> A few days later, when I visited her and greeted her as usual ('Hello Ada, how are you?') she answered, 'Very well, thinking life is worthwhile living. I have just decided that I will not give in easily.' It was September-October 1988. Her clinical condition was stable and balanced. She had definitively lost her eyesight. Through those months there were lapses, and moments of great depression. But, in general, Ada's psychological state was good" (Pintos, 1993; pp. 32-33).

(5) Illustrating Meaning-Possibilities:

"*True friend is the one who listens to the melody of your heart, and can remind you of it when you have forgotten about it*" (Lukas, 2000).

In logotherapy meaning is never given, but the **possibility** where meaning can be seen is highlighted. This possibility can be chosen from attitudinal, creative, or experiential values. It may not always be the easiest possibility, but it has to be something that is realistic—really possible to accomplish.

Sometimes, what therapists can highlight, is not present meaning, but future meaning that has to be "waited out."

Alternatively, there are situations in which there seems nothing left to do. However, "nothing to do," can be still a meaningful possibility.

The **acceptance** of unavoidable situations requires self-transcendence that illustrates the most heroic capacities of the human spirit:

> Dr. Barnes, Chair of the Department of Counselling and Human Development at Hardin-Simmons University, and President of the Viktor Frankl Institute in the United States, has been suffering from the symptoms of poliomyelitis since his adolescence. Both of his legs are paralysed from the hips down.
>
> Speaking through his life experiences in the article entitled "*Finding Meaning in Unavoidable Suffering*" Dr. Barnes inspires others never to give up hope. Hope, coupled with faith, that life is available under all circumstances:
>
> "I myself live within a body that has major limitations because I had polio when I was 13, two years before the polio vaccine was available. My body is crippled, but I as a person am not. My soma (body) became sick. My psyche (my emotions) experienced healing through the acceptance that my body had limitations, but my life does not need to be shaped by those limitations. Our noetic dimension (our spirit) can never get sick. Somehow in my noetic dimension, even as a teenager, there was an awareness that I am a whole person, that the Creator has purpose for my life, and that no disease took away anything I needed for the tasks that await me. As a spiritual being, I am not even slightly diminished by having a lame leg. In fact, I can truly say that, because the opportunities I have had to serve and to help others, my life is extraordinarily rich in meaning" (Barnes, 1994, p. 24).

For patients who are religious, **prayer** is an acceptable possibility. So is the **wisdom to wait in patience**, and realise the uniqueness and irreplaceability of the person, even in the face of situations which can not be changed.

In any of these instances, the language of logotherapy is never imposing, and never commanding, or demanding. Meaning possibilities are discussed frankly, often with emphasis, but always politely, and with respect. Many times, Frankl used the form: *"Can it be…" "Is it possible that…"* to preface a suggestion, a possible way of seeing things, or responding, which was out of solidarity with his patients in a search for meaning in a reverent, and modest way.

Case 8: Discovering Meaning-possibilities Through Religious Convictions

> "….A rabbi from Eastern Europe turned to me and told me his story. He had lost his first wife and their six children in the concentration camp of Auschwitz where they were gassed, and now it turned out that his second wife was sterile. I observed that procreation is not the only meaning of life. For then in itself would become meaningless, and something which in itself is meaningless cannot be rendered meaningful merely by its perpetuation. However, the rabbi evaluated his plight as an orthodox Jew in terms of despair that there was no son of his own who would ever say Kaddish for him after his death.
>
> But I would not give up. I made a last attempt to help him by inquiring whether he did not hope to see his children again in Heaven. However, my question was followed by an outburst of tears, and now the true reason for his despair came to the fore: he explained that his children, since they died as innocent martyrs, were thus found worthy of the highest place in Heaven, but as for himself he could not expect, as an old, sinful man, to be assigned the same place. I did not give up but retorted: "Is it not conceivable, Rabbi, that precisely this was the meaning of your survival of your children; that you may be purified through these years of suffering, so that, finally, you, too, though not innocent like your children, may become worthy of joining them in Heaven? Is it not written in the Psalms that God preserves all your tears? So perhaps none of your sufferings were in vain.' For the first time in many years, he found relief from his suffering through the new point of view which I was able to open up to him" (Frankl, 1984; pp. 122-123).

(6) The Socratic Dialogue:

While the *Socratic Dialogue* represents a relatively new development among the logotherapeutic methodologies, its theoretical background reaches back to ancient times in history. It derives its name form the philosopher Socrates (469-399 B.C.), whose thoughts were known to the Greeks, and revised by Plato (427-347 B.C) and Aristotle (384-322 B.C).

According to the historical account, Socrates' mother was a midwife. Her profession inspired Socrates to develop a unique way of reflection, and teaching, which brings new ideas to "life." He championed the "*Maietuic Questioning*" (the name derives from the school he represented), which was characterised by the use of critical questioning, and reflection, rather than direct teaching, to elicit thoughts and reflections, which would bring his students closer to knowledge, and to wisdom (Gould, 1988).

An avid believer in turth and morality, the purpose of the *Socratic Dialogue* was to help his students discover themselves through a discourse. He considered that the role of a good teacher was not to pour information into the head of his students, but, rather, to make conscious what deep down, in their **unconscious selves**, they already knew to be true.

Following Socrates's aim, a common element in several theraputric approaches is to bring new insights to light through a **narrative**: Both logotherapy, and traditional psychoanalysis, for example, aim to bring unconscious contents to the level of conscious awareness.

However, charecteristic to logotherapy, is that it expands on the concept of the unconscious, and regards the unconscious not only as the "reservoir" of repressed instinctiual drives, but also the store of **spiritual aspirations**, which can be pre-conscious or unconscious, to the extent that we can not directly express them, or reflect on them, unless they are brought to the level of conscious awareness. The effort to bring our spiritual aspirations to the conscious awareness is crucial in the prevention, or, in the treatment of Existential Vacuum, and Noogenic Neurosis (Fabry, 1994).

We have mentioned earlier that logotherapy is future oriented, and considers human beings, not only as **factual-**, but as **facultative beings**--not only as we **are**, but as we **can be**.

The **future orientation**, and the tendency to "*…treat individuals as they can be, rather than as they are, so as to help them become what they can be*" (Goethe) distinguishes logotherapy's *Socratic Dialogue*, from the application of the same method, more recently incorporated into the dialogue forms of other schools of therapy, such as the Socratic Dialogue in Cognitive-Behaviour Therapy (Padesky, 1995).

Another feature of the use of this method in logoterapy is that *"...unmasking and debunking should stop as soon as one is confronted with what is **authentic and genuine** in man, such as his desire for a life that is as meaningful as possible. For, if it does not stop, then, the man who does the debunking merely betrays his own will to depreciate the spiritual aspirations of another*" (Fabry, 1994; pp. 147-148).

The Socratic dialogue is the vehicle for mobilizing the inner resources of the human spirit, whenever **modification of attitudes** and **self-transcendence** are called for:

> In logotherapy "…the Socratic dialogue, or self-discovery through discourse, enables patients to get in touch with their Noetic unconscious, and become aware of their true evaluation of themselves, and their potentials; their preferred directions, and their deepest meaning-orientation. From childhood, they have put on masks in order to please, to be accepted, and to avoid guilt. The self-discovery discourse helps patients discover their selves under the mask—the beautiful selves that can be actualized toward meaning and the ugly selves that can be improved or at least honestly accepted" (Fabry, 1994; p. 135).

The technique of the *Socratic Dialogue* was first mentioned in Dr. Frankl's book "*The Doctor and the Soul*" (1986; p. 283). In explaining the essence of this method, Frankl stated that the logotherapist recognizes that the search for meaning is a never-ending journey. He or she joins the patient in the pursuit of meaning as an equal partner. The therapist may challenge, and has the obligation to challenge patients whenever their attitudes are self-destructive, but challenging in logotherapy is always done with empathy. The encounter between the therapist and the patient (or group participants) never becomes hostile and negative; therapists and patients are allies in their common search for a way out of frustration and emptiness.

The *Socratic Dialogue* may start out with a struggle between patient and therapist, but it becomes a **shared struggle** in the search for uniqueness, choice, responsibility, response-ability, self-distancing, and self-transcendence—the avenues to realizing a deeper meaning in life.

According to Welter (1987), the therapist's **Socratic questions**, and the patient's **responses** to these questions make up the **dialogue**. The therapist's questions are usually aimed at bringing about a greater clarity, to lead to increased self-awareness and to deepen a look within to verify where freedom lies, so that patients can begin to be responsible. "*It is when people feel predetermined that they are irresponsible—not able to respond*" (Welter, 1987; p. 69).

> "Yoder [Dr. James Yoder, a logotherapist and psychologist in Kansas City] makes the point that the Socratic dialogue should be specific. He notes some Socratic questions from actual counselling sessions: '*What did you feel*?' rather than 'How did you feel?' 'What does the present situation demand?' '*Something keeps you from behaving this way. What is it?' 'What did you discover from that experience?' 'What are you learning about yourself as you experience this very human struggle*?' [Yoder, 1985; p. 104; cited in Welter, 1987; p. 69]. By such questions, Yoder says, 'the counsellor urges the client to look beneath the surface, not to be content with generalities and quick explanations about behaviour' [Ibid]. Therefore, it may be seen that the Socratic dialogue produces depth in the conversation" (Welter, 1987; p. 69).

Dr. Welter (1987) continued to explain that *Socratic questions* can be thought of as "**two-legged**" questions:

> "Socratic questions need to be asked in a way that stretches the thinking of the client. This requires careful listening to find the circumference of the client's thought. If the question is entirely within the circumference, it will not have a stretching quality. If it is totally outside of the client's thought, he or she will not be able to connect with it. The question needs to stand with one leg firmly in the client's way of looking at the world, and the other in the new territory (Welter, 1987; pp. 69-70.).

On the basis of the above writings, we can establish that the general rules of the *Socratic Dialogue* are the following:

1. **The questions are aimed to stretch thinking further, and are specific;**
2. **The questions are open-ended rather than closed;**
3. **The questions are thinking-oriented rather than feeling-oriented;**
4. **The questions start from the present or the past, and are future-oriented;**
5. **The questions aim to facilitate:**
   - **(a) Self-discovery [knowledge];**
   - **(b) Choice [decisions];**
   - **(c) Uniqueness [Personal Significance];**
   - **(d) Responsibility;**
   - **(e) Self-transcendence;**
   - **(f) Clarify Needs, and Values.**

Examples of questions which foster insight, and foresight, for students in the classroom, according to the **Socratic principles**, can be found in the article "*Finding Meaning Through Frankl's Socratic Dialogue, and Fromm's Five Needs of the Human Condition*" (Wilson, 1997), and in an unpublished manuscript written by Dr. Robert Wilson, in 1995: "*Socratic Dialogue: Questions that Enhance the Search for Meaning*."

Examples which encompass **self-discovery** in the above mentioned areas include: (a) "*What are some of your greatest strengths?" "Whew was the time that someone expected the very best of you?"* (b) *"What are two things you may do in the future that as of yet you have not done?" What was time when you put off something you should have done right away?"* (c) *"What was it like for you when someone did not accept your point of view?" "What would you say were 'key' turning-points in your life?'* (d) *"What was one thing you forced yourself to so and it was good afterwards?" "What are some things you want to learn in the future?" "Name something that you finished that you had a hard time starting?"* (e) "*When was a time when you put energy into something you believed in?*" "*When was a time that you were of real help to someone in difficulty?*" (f) *"What are three things that someone else wants you to be?" "What are two things that are difficult for you to accept?"* (Wilson, 1995; pp. 7-25).

Scraper (2000) noted that, beyond its rules, the skilful application of the Socratic dialogue is an **art** (Scraper, 2000), which often requires considerable experience from the therapist, not only to determine the right context in which the discovery can take place, but its correct timing.

> "The Socratic questioning needs to be separated from questions that are used for information gathering or clarification. While the use of such questions is useful in many therapies, Socratic questioning is different in nature and purpose. The timing and placement of a conversation is crucial to their successful use. This makes them both art and science" (Scraper, 2000; p. 15).

Socratic questions often seem **improvised**. This is for the sake that they arise out of a genuine communication with the patient, in which the therapist is encouraged to give voice to his or her own questions, especially those that *"...help to connect disparate meanings as they arise* (Scraper, 2000).

The *Socratic Dialogue* is **powerful** because it creates and image, or a key sentence, which stays with patients that they can think about even after they have left the office.

Often, the images, metaphors, and wisdom that are gained represent a **paradigm shift**, a new way of seeing the self, and the world, which occurs once the defences (such as rationalisation; Scraper, 2000) are no longer held.

For a skilful application of the *Socratic Dialogue*, let us consider a few examples. The first, was presented by Dr. Lukas (1986) in her book *Meaningful Living:*

The dialogue takes place between the therapist and a woman who had "everything," yet, she stayed in bed much of the day to the pity of those who loved her. The therapist suspected that she "needed to be sick," and asked her the following thought provoking question:

> "'You stand among the flowers and water the weeds,' I once told the patient and she laughed. 'That's exactly what I do,' she said. 'Why?' I kept asking. 'Why?' 'That's why I come to you,' she said. You water the flowers, I water the weeds'" (Lukas, 1986; p. 136).

Another famous example of the use of *Socratic Dialogue* is found in Frankl's *Psychotherapy and Existentialism*:

> "Once, an elderly general practitioner consulted me because of his severe depression. He could not overcome the loss of his wife, who had died two years before, and whom he had loved above all else. Now how could I help him? What should I tell him? Well, I refrained from telling him anything, but instead confronted him with the question: 'What would have happened, Doctor, if you had died first, and your wife would have had to survive you?' 'Oh,' he said, 'for her this would have been terrible; how she would have suffered!' Whereupon I replied, 'You see, Doctor, such suffering has been spared her, and it is you who have spared her of this suffering; but now you have to pay for it by surviving and mourning her.' He said not word but shook my hand and calmly left my office. Suffering ceases to be suffering in some way at the moment it finds a meaning, such as the meaning of a sacrifice (Frankl, 1967; p. 38).

On the basis of the above two examples, Scraper (2000; p. 16), lists three ways in which effective *Socratic Questions* can be formulated:

1. "The Comparison Technique:" the essence of this method is to compare a present state with a future alternative. The comparison invites the re-evaluation of the situation, to see it in a different way, i.e., the way guided by the comparison.

2. "The Transcendence Technique:" Frankl's case with the elderly physician illustrates this method, with the explanation of the meaning behind the tragedy, and a direct appeal for self-transcendence.

3. "The Contemplation Technique:" This technique requires to ponder and reflect on questions and answers to them to discern meaning, on the basis of the therapist and the patient's current, and shared understanding.

Dr. Scraper (2000) mentions that even though *Socratic questions* have been around for such a long time, the **science** and the **art** of formulating and using Socratic questions is a new endeavour, which will certainly require a lot more attention from therapists and researchers in the future.

At the present, its right application requires considerable training and experience, along with the willingness for **spontaneity**, **improvisation**, and **authentic communication**. The Socratic Dialogue also requires the therapist to be **committed, flexible, open to meaning in his-, or her own life**, and **willing to listen; willing to take risks,** willing to **learn**, and to be willing to **discern**. It requires a **collaborative approach** to therapy, in which the patient is skilfully and wisely accepted, and guided.

Lukas (1986) made two observations: First, that *Socratic Dialogue* is most effective in the right moment, when patients are ready for it. In such cases, one powerful image may be enough to help patients distance themselves from their symptoms.

The second consideration is that therapists need to know the moment when silence is more curative than words. This is when patients think about images, they reflect on words, and try to relate them to their lives. This is the time when patients are slowly gaining their independence. And, while therapists can lead and encourage, at this point, they must quietly step back, with nothing more to add.—Both considerations require talent, and experience.

The *Socratic Dialogue*, as it is currently known to logotherapists, deserves further exploration and refinement (Scraper, 2000). However, its significance can not be underestimated:

> "Logotherapy has been given credit for 'rehumanizing' psychotherapy, and the Socratic Dialogue is its main vehicle for the rehumanization. Abraham Maslow, in *Religion, Values and Peak Experiences*, points to the I-Thou encounter between existential therapist and patient that the mirror-type therapist cannot achieve. 'Even the classical psychoanalysis would now be willing to admit,' Maslow says, 'that care, concern, and agapean love for the patient are implied by the analyst in order that therapy may take place.' But even this therapist-patient encounter on the human level is not enough. Logotherapy, says Frankl in *Psychotherapy and Existentialism*, goes a step further and opens that two-sided relationship to include a third 'partner'—meaning. The Socratic dialogue is an I-Thou relationship between therapist and patient directed toward meaning" (Fabry, 1994; p. 137).

CASE EXAMPLES:

Poignant illustrations of "*logotherapy in action*" rely on the use of *Socratic Dialogue*. Below, we present three such illustrations:

Case 8: Regaining Basic Trust.

A fragment of Dr. James Yoder's Socratic Dialogue with a young man was presented by Fabry (1988). The patient suffered from self-depreciation, and dreamt about a silver wire dangling out of the power plant in his chest. The fragment illustrates how Socratic dialogue can be applied to highlight the positive, affirmative phrases from bits of dreams, goals, and experiences, and "play them back" to the patient, so that he becomes conscious of them:

Fred: (After telling about his life which is full of disappointments): I'm afraid sometimes to take another step—not sure whether it will make sense.
Yoder: Let's look at your past. If your past is like a web of spider spins (Fred had used that phrase), what kind of web do you spin? Your life seems to contain jewels of achievements, experiences, relationships.
Fred: Yes, I would say so.
Yoder: No one can take them away from you. What do you learn from looking at your past, full of such jewels?
Fred: I do learn, even though I really feel down and deserted. A part of me is resting up, getting ready to take another shot at life, later. (He tells Yoder that he read Frankl's account of his experiences in the concentration camps.)
Fred: I have been thinking about what Frankl said all week, ever since I read that.
Yoder: What goes through your mind?
Fred: I must say, pessimism. I see myself as probably being one of those who would not have survived, emotionally, spiritually, and that's not entirely true. I have some hope for myself. I see myself as one of the 90% who did not remain spiritually intact…as one who would sell my brothers to stay alive…but the fact that Frankl shows that some did not compromise and they still stayed alive proves that one can survive.
Yoder: Talk about hope. I heard you say you still have hope.
Fred: Yes, I…I refuse to write myself off, and yet I (slides back into stories about rejections and traps).
Yoder: As Frankl says, every person has his or her own concentration camp. Tell me about yours, and about your emergence, your hope. The very fact that you sit here today discussing your pain, your freedom of choice…your mention of hope demonstrates that you have survived.
Fred: Well…I think that is true. How did I manage to get out? Certain people cared about me.

After this dialogue, Fred told the therapist about people who cared for him, and about this dream, which Dr. Yoder used to show Fred how he wants to live his life. Yoder reported that this was the turning point in the session. Fred has become receptive to seeing himself in a more positive light.

Yoder's comment of the dialogue was: 'Always the clients are affirmed for their positive and courageous stand amidst all their suffering. From this session alone, I knew that Fred was well along the road to recovery, transcending his feeling of meaninglessness and depression" (Fabry, 1988; pp. 25-27).

Case 9: Grief-counselling.

The following case study was reported by Dr. Hiroshi Takashima, the author of the book *Humanistic Psychosomatic Medicine* (1990). On his lecture-tour on logotherapy in Australia, Dr. Takashima was asked by one of his colleagues to see a 50 year-old woman, one of his colleague's patients, who had recently lost her daughter, and suffered from depressions and anxieties. In her depression, the woman attempted to commit suicide, and when the attempt failed, she became even more depressed. Dr. Takashima could see her only for a brief period of time, during which the following conversation took place:

Question: If your daughter were alive, who amongst you would suffer?
Answer: My daughter.
Question: Do you still love her?
Answer: Yes, very much.
Question: Would you be willing to suffer instead of her, if she were alive?
Answer: Of course, I would suffer willingly.
Question: But she has already died and cannot suffer. And thus you can suffer instead of her—if someone has to suffer. Let me give you an example: Suppose that suffering is like water. You are now drowning in the water and you try to save yourself, despite the feeling that it can't be done, correct?
Answer: I simply cannot.
Question: But in the water of suffering you can swim instead of drowning, isn't it?
Answer: Yes, I think so.

Takashima added:

"This simple, uneducated woman was able to understand that suffering had a meaning and she accepted it. She changed her attitude to suffering, from the negative and self-destroying to positive, and constructive one. She and her husband held hands. She cured herself by her wisdom, orientation to meaning, and free decision" (Takashima, 1990; pp. 98-100).

Case 10: Accepting Fate.

The following dialogue took place between Frankl and an 80 year-old woman, Mrs. Kotek, who suffered from incurable cancer, and was depressed [Chapter I makes reference of her case]. The emphasis of the dialogue is to illustrate the wisdom that "what we have accumulated in our granaries of our past can never be taken away from us." "Everything there is kept safe and sound, deposited until claimed" (Guttmann, 1996; p. 157):

Frankl: What do you think when you look back at your life? Has life been worth living?
Frau K.: Well, Doctor, I must say that I had a good life. In truth, I had a wonderful life, and I have to thank God for what my life gave me: I went to theatre, and to concerts, and…with the family in which I served as a maid for decades, first in Prague and later in Vienna. And for the grace—for all those wonderful experiences, I thank God.
[*I nevertheless felt that she was also doubtful about the ultimate meaning of her life and I wanted to steer her through her doubts, so I had her question the meaning of her life on the conscious level rather than expressing her doubts*.]
Frankl: You are speaking of some wonderful experiences, but all this will end now, won't it?
Frau K. (*thoughtfully*): Yes, everything ends…
Frankl: Well, do you think now that all the wonderful things of your life might be annihilated?
Frau K. (*still more thoughtfully*): All those wonderful things…
Frankl: But tell me—do you think that anyone can undo the happiness that you have experienced? Can anyone blot it out?
Frau K.: No, Doctor, nobody can blot it out!
Frankl: Or can anyone blot out the goodness you have met in your life?
Frau K. (*becoming increasingly more emotionally involved*): Nobody can blot it out!

Frankl: What you have achieved and accomplished—
Frau K.: Nobody can blot it out!
Frankl: Or what you have bravely and honestly suffered: can anyone remove it from the world—remove it from the past where you have stored it, as it were?
Frau K. (*now moved to tears*): No one can remove it! [Pause.] It is true, I have had a great deal to suffer; but I also tried to be courageous and steadfast in enduring what I must. You see, Doctor, I regard my suffering as punishment. I believe in God.
Frankl (*trying to put myself in the place of Mrs. K.*): But cannot suffering also be a challenge? Is it not conceivable that God wanted to see how Anastasia Kotek would bear it? And perhaps he had to admit, 'Yes, she did so very bravely.' And now tell me: can anyone remove such achievement and accomplishment from the world, Frau Kotek?
Frau K.: Certainly, no one can do it!
Frankl: This remains, doesn't it?
Frau K.: It does!
Frankl: What matters in life is to achieve something. And this is precisely what you have done. You have made the best of your suffering. You have become an example for our patients because of the way you take your suffering upon yourself. I congratulate you for this achievement, and I also congratulate to the other patients who have the opportunity to witness such an example.
[*To the audience*.]
Ecce homo! [*The audience bursts into spontaneous applause*.] This applause is for you, Frau Kotek. [*She is weeping now*.] It concerns your life, which has been a great achievement. You may be proud of it, Frau Kotek. And how few people may be proud of their lives…I should say, your life is a monument. And no one can remove it from the world.
Frau K. (*regaining her self-control*): What you have said, professor Frankl, is consolation. It comforts me. Indeed I never had any opportunity to hear anything like this….
[*Slowly and quietly leaves the lecture hall*.]

A week later she died. During the last week of her life, however, she was no longer depressed, but, on the contrary, full of faith and pride. Prior to this, she had felt agonized, ridden by the anxiety that she was useless. Our interview had made her aware that her life was meaningful and that even her suffering was not in vain. Her last words were: 'My life is a monument. So Professor Frankl said, to the whole audience, to all the students in the lecture hall. My life was not in vain…' (Frankl, 1984b; pp. 121-124).

POINTS TO PONDER:

* Meanings have an appellative, imperative value for logotherapists as they are prompted to search for those areas in which meanings can be found, and share this discovery with the patients in a dialogue. Yet, therapists are very far from being all-knowing.

With the words of Albert Einstein, Frankl (1975; p. 129) suggested that "*Wisdom is knowledge plus: knowledge—and the knowledge of its own limits*" (Frankl, 1984; p. 142). And, in another place he noted: "*We have to learn from the wisdom of the heart of our patients, and have to learn from them about humanity*."

What can we can learn form other people, and why would this be relevant for psychotherapists?

Chapter IX: Other Logotherapeutic Methods

Aside form the well-known logotherapeutic techniques of *Paradoxical Intention*, *De-reflection*, *Modification of Attitudes*, and *Socratic Dialogue*, the following methods appear in Dr. Frankl's original writings, mostly represented through case examples, which were described in considerable detail by other logotherapists, who extended, and expanded on his original work. --Today, these techniques are part of the "**logotherapeutic toolbox**," and can be used along with the techniques described earlier.

(1) Logodrama:

The theoretical background behind the use of *Logodrama* is the fact that therapists cannot give meaning to their patients, nor can they prescribe meaning. They may at times, when they carefully listen to the words that are spoken, infer possible areas where meanings can be found, and tasks that can be meaningful to patients, but they can not impose the significance of meaning, or the order in which patients ought to live their lives. To do so, would be an imposition of values, or control, that would create a child-like dependency on the therapist, and an unhealthy giving up of freedom and responsibility, which is the opposite of the goals of logotherapy.

Instead of telling their patients about what are the most significant tasks that await them in life, which they can not have a general sense in advance, logotherapists **ask their patients for their own insights**. It is of course with the recognition that meanings may change with time, and in particular situations, however, with the appreciation that what patients know at the time is where they have a freedom and where meaningful tasks await them.

Logodrama requires some **imagination** from patients. In general, its process is as follows: The therapist asks patients to think about the time when they will be ninety years old, or close to the time of their death, on their death bed. Putting themselves in this situation, in their imagination, they are to reflect back on their lives and ponder if they are satisfied, and pleased with their lives, as it had been. Looking back on their lives, what were their major accomplishments, and what would give them a sense, that at the end, they can be satisfied with themselves, and their lives have been worthwhile?

In the book *Psychotherapy and Existentialism*, Frankl (1967; pp. 39-40) described a case example using this technique in group therapy, where he asked a woman who could not accept the loss of her son, to imagine herself from the perspective of being able to look back upon her life:

> "The mother of two boys was admitted to my clinic after an attempt at suicide. One of her sons was crippled with infantile paralysis and could be moved around only in a wheel chair, while the other son had just died at the age of eleven. My associate, Dr. Kocourek, invited this woman to join a therapeutic group. While she was conducting psychodrama in this group, I happened to step into the room, just as this mother was telling her story. She was rebellious against her fate, she could not overcome the loss of her son, but when she tried to commit suicide together with the crippled son who was left, it was the latter who prevented her from suicide. For him life had remained meaningful. Why not for his mother? How could we help her to find meaning?"

> "I asked another woman in the group how old she was. Upon her reply that she was thirty I retorted: 'No, you are not thirty, but instead eighty now and lying on your death bed. You are looking back upon your life, a life which was childless, but full of financial successes and social prestige.' I then invited her to imagine what she would feel in that situation. 'What will you think of it? What will you say to yourself?' Let me quote her answer from the tape that recorded that session: 'Oh, I married a millionaire; I had an easy life full of wealth; and I lived it up! I flirted with men. I teased them! But now I am eighty; I have no children of my own. Looking back as an old woman, I cannot see what all that was for; actually, I must say, my life was a failure!'
>
> Then, I invited the mother of the crippled son to imagine herself in the same situation. Again, I quote from the tape: 'I wished to have children, and this wish has been granted to me; one boy died, the other, however, the crippled one, would have been sent to an institution if I had not taken over his care. Though he is crippled and helpless, he is after all my boy. And so I have made a fuller life possible for him; I have made a better human being out of my son.' At this moment she burst into tears but continued: 'As for myself, I can look back peacefully on my life; for I can say that my life was full of meaning, and I have tried hard to fulfil it; I have done my best—I have done the best for my son. My life was not a failure!' Anticipating a review of her life as if from her death bed, she suddenly was able to see a meaning to her life, a meaning which even included her sufferings. By the same token it had become clear to her that even a life of short duration like that of her dead boy could be so rich in joy and love that it contained more meaning than some life that lasts eighty years" (Frankl, 1967; pp. 39-40).

The capacity of the human spirit to transcend time, to move between the past and the future, can be used, and mobilized with this technique to seek to transcend suffering and to see a world in which unavoidable suffering can also have meaning. Success, and failure are artificial-, and very relative terms. While we readily think of our lives in terms of the definition of others, it is our own self-evaluation that this technique brings to mind: *In our own eyes how do we appear? What are the facts of our life? How do we feel about them? What do we think about them? Is there still something left to be done so that we can live more meaningfully*?

The same principle was presented in the article entitled: "*Logodrama and Philosophical Psychotherapy*" by Sahakian (1986), where we find the case example of a young woman, who presented with numerous problems, dysfunctional coping patterns, and a life of disarray, and who sought to resolve them. The therapist asked her to imagine that she is in her nineties and looking back on her life. She was asked to list at least four or five tasks that would make her feel and think that her life was lived well. First, to list whatever came to her mind, and then to rank order the achievements and accomplishments she thought of as important according to significance. Once, this was done, the therapist's task remained to support her in accomplishing these goals, which she started to undertake by herself.

(2) Life-review and Life-preview Exercise:

As an expansion from the concept of *Logodrama*, Dr. Mignon Eisenberg (1985), asked college students to review-, and to pre-view their lives, and to interview older persons about their lives (2000). This **intergenerational sharing project**, which lasted at the for ten years, under Dr. Eisenberg's leadership at various Universities in Israel, brought forth fruitful lessons to be learned about life, and resulted in renewed spirits to make life as meaningful as possible.

A **life-review and life-preview exercise** was presented to participants of a seminar by Dr. Lukas, and cited by Dr. Barnes (1995):

> Imagine a roll of unfinished camera film. It is a kind of film that we usually take to the photo lab to develop. As you unroll it, it has several snapshots, followed by a heavy black line, after which there are no more visible exposures.
>
> "The film represents an individual's life. The heavy black line of the film represents the moment of death. The remainder of the film can not be exposed. At the end of life, the film is completed. We have no more exposures on our film, we have no more life. We <u>are</u> our life. The length of our life is not important, only the quality is important. The quality of our life is determined by what is 'ours' (our merit, or our guilt).
>
> In the illustration of the camera film, each past event, each slide, print, or exposure, represents an event in our life. What happened because of us is the answer we gave to the 'scenery' of our life's film. This is what we allowed to happen, or helped through the door, when we were the gatekeeper. Perhaps, many of the scenes from our 'film' deserve a plus sign. Others may surely deserve a minus.
>
> Speculate on the yet unexposed part of your life's film. There are valleys into which each of us will descend. And there are beautiful peaks to which we may yet climb. Often we realize the greatest meaning in our accomplishments when we are aware that we have helped another along the way. There are only so many exposures left on our life's film. *What are your goals for the remainder of this phase of your life?* Logotherapy teaches that each person's life is his or her own responsibility. Life does not owe us happiness, it offers us meaning." (Barnes, 1995; p. 26-27).
>
> "...The meaning of our life is the light we have brought into the world. The light we brought into life is eternal, it can never be made into darkness. We should help others to see the eternal light in their own lives. One gift we can give to others is to reassure them that they have not lived in vain" (Barnes, 1995; p. 26).

In a light-hearted and fun filled exercise, Dr. Welter, and Dr. Hutzell (1995) complemented the life life-review, and life-preview project with a metaphor of using a videotape to record one's life, and creating an **imaginary film-production**, as if one was the main character. It is possible to "review" and "fast-forward" the film, and to record it in real life as a brief script, or an audio-tape (Welter, 1995; Graber, 1995).

Developmentally, it is usually the case that while young individuals have a "*fewer*" number of meanings actualised and an apparently "*larger*" pool of potentials still ahead of them; the elderly have much in their "granaries," already stored away, and less "*yet to be accomplished*" (Lukas, 1995; p. 15). Increasingly, as life progresses, there is a potential in older age to rely and to use spiritual resources, and wisdom, and to teach, and inspire the younger generation about how to do the same (Popielski, cited in Lukas, 1986; p. 77).

It is this "*granary of the past*" which therapists can use to guide the aged, and to comfort them, when they are close to finishing their task on earth (Abrami, 1997).

However, since logotherapy believes that life can be made meaningful, even retroactively, flooded with meaning, in every instance, each good deed, or courageous attitude, a life-preview can be helpful to examine what in life is still left to be accomplished.

(3) Guided Autobiography:

A very thorough life-review, and life-preview exercise was presented by Dr. Lukas (1995b) in a four-day seminar. She presented a model for a **structured guided autobiography** encompassing nine stages of life: (1) "*My Parents*;" (2) "*My Early Childhood*;" (3) "*My School Years*;" (4) "*My Early Adulthood*;" (5) "*My Present*;" (6) *My Near Future*;" (7) "*My Distant Future*;" (8) "*My Dying*;" and (9) "*The Traces I Want to Leave on Earth*."

This exercise confronted participants with meaning at all of its stages. The instructions were to list these developmental stages on one side of a notebook, with the following guiding questions in mind, on the other side: (1) "*What are the facts*?" (2) "*How do I feel about this now*?" (3) "*What do I think about this*?" and (4) "*What stand do I take toward this*?" "*How do I respond to this?" "Do I accept it?", or, "Is there something else to be done about this?"*

This guided autobiography is usually a one-year project at the South German Institute of Logotherapy for those students who intend to practice as logotherapists. The content is for oneself to reflect and to meditate, and to share only what one wants to share with the rest of the group.

(4) Guided Discovery of Meaning Potentials:

This is a written assignment, developed by the author, on the basis of a similar exercise described by Dr. Lukas ("*Five Bears*;" 1984; pp. 67-84); and concepts form the "*Logochart*", developed by Dr. Khatami (1988). It can be applied in response to an event, which left patients hurt, feeling angry, vulnerable, surprised, puzzled, or wondering, and where they are searching for a meaningful response. Instead of quick, automatic, impulsive, or habitual responses, the exercise can help to find self-transcendent, "**authentic**" responses (Khatami, 1990; pp. 83-88), and finally, the response that they think is most meaningful.

In this paper and pencil assignment, first, one needs to describe the **facts**: "What happened?" In the row below the facts, one is asked to describe the **feelings** accompanying the event: "*How did I feel about this at the time*?", and, in a separate column, "*How do I feel about it now*? In the next row, one is asked to examine one's **thoughts** about this event: "*What did I think about this at the time*?" and "*What do I think about it now*?" Next, in the row below, one is asked to ponder: "*Where is my area of fate and freedom in regard to what happened*? "*What is my responsibility about what happened*?" In the row below, one is asked to ponder: "*What meaning possibilities do I see perhaps hidden in this situation?*" and *"What possible choices do I have?"* "*Is there something that is still unfinished*?" "*Is there something to be done, experienced, or do I need to take a particular stand*? Next, one is asked to **list** all **possible choices** in response to the event, and to evaluate them with regard to their expected outcome for the person, and for those who are involved. The final task is to see "*Which one of these I think I can manage to accomplish*?"; "*Which one of these would make me feel that I have done a good job*?"; *"Which one of these could I live with peacefully*?"

This technique is most effective when there is follow-up from the therapist. It can be taught to patients, so that they reflect on their decisions and see where they have acted according to their conscience.

(5) Logotherapeutic Dream Analysis:

The first description of logotherapeutic dream analysis can be found in Frankl's book *The Unconscious God* (1975pp. 40-51) under the title "*Existential Analysis of Dreams*." What Frankl put forward as specific about the Existential Analysis of Dreams starts with his notion of the **unconscious**.

From the Chapter on the *Anthroplogical Foundations of Logotherapy* we know that whereas Frankl postulated a rigid line between the dimensions of body and mind, and spirit, he envisioned a fluid line between its conscious and unconscious areas. In the "*Existential Analysis of Dreams*," his intent was exactly this; to identify those dream contents which his patients reported and which clearly indicate that there are spiritual contents and discernment that is available *unconsciously*-, or *pre-consciously* through dreams, and can be accessed through dream analysis, but only from an existentialist perspective—by acknowledging their reality.

Frankl noticed that many of his patients held deep convictions, and were very spiritual, even religious. Authentic, deep seated **religiosity**, and **spirituality** are always very personal, and not easily discussed, yet recognized as significant resources in therapy (i.e., Abrami, 2001; Bulka, 1980; Chakravati, 1987; Kimble, 1979; Lukas, 1998b; Pacciola, 1993; Scraper, 2002; Takashima, 1985; Thompson, 1987; van Pelt, 1994; Welter, 2003).

One way of facilitating access to the deep seated resources of our **unconscious spirituality** is through dreams: In dreams, we connect to an infinite point of trust in ourselves through our conscience, where there is an inner dialogue taking place between the transcendent and the concrete, and subjective, and where we can not readily put such contents into words, as we can talk to the source of our inner spiritual guidance, but we can not talk about it.

In existential analysis of dreams, religious and spiritual contents appear, and if the therapist asks, patients will report them, in order to discern their personal significance in their lives. Frankl (1975) reported several examples where dreams were the "**royal road to the spiritual unconscious**" (Fabry, 1989; pp. 70-121).

Among them we will consider one which illustrates that dreams can not only be warning--they can not only be interpreted simply along the lines of psychodynamics, although they certainly contain these elements--but they can also convey "messages" from the wisdom of the heart, desires, and spiritual truths:

> "A patient dreamed that his father handed over some saccharine to him, but he refused it with the proud remark that he would rather drink coffee or tea bitter than sweetened with some sort of sugar-substitute. The free association went literally as follows: 'handed-over—tradition; but the tradition I got from my father is our religion.' The patient continued to associate, saying that the evening before the dream he had read a magazine article recording a dialogue between a philosopher and a theologian. The argument of the existential philosopher seemed very plausible to him, and above all he was impressed by the philosopher's rejection of

existentially inauthentic religiosity, in particular where the philosopher refused to 'flee into the realm of belief and dream' and he exclaimed, 'What sort of motive is it to want to be happy? What we want is truth.' So, also here, in his wide-awake life, the patient renounced inauthenticity. The same evening the patient had heard a radio sermon which he felt somehow to be cheap consolation—and somehow 'sweetish.' It also turned out that at one point in the magazine article the question was asked, 'What is it like when the taste for living is lost?' With that in mind we can understand quite well why the existentially inauthentic religious tradition was associated with the realm of taste, and why the image chosen in the dream was the sugar substitute saccharine, taking the place of the genuine sweetener. This choice of symbols becomes fully clear when we learned that the patient's good luck piece was a religious icon; and that he disguised it from unwanted viewers by carrying it in a small wooden box which originally served as a package for saccharine" (Frankl, 1975; pp. 43-44).

More recently, Lantz (1997) reported on the use of dream-reflection with clients in logotherapy to help them "**notice**" (p. 95) meaning potentials in the here and now, and "**re-collect**" and "**honour**" (p. 95) meanings actualized and deposited in the past.

Two of his most vivid case examples are cited below:

Case 1: "Noticing in a Dream by Bill."

"Bill presented the following dream in his ninth logotherapy treatment interview:

I was working with a bunch of men in a coal mine. The men left me off at the ninth level and went down a long tunnel to a wall of coal. My job was to dig out the coal so I used my pick axe and started to dig the coal. After a few minutes of digging I heard a voice from behind the wall of coal. I got scared, and then I woke up. I've had this dream about four or five times, and I always wake up when I hear the voice. It's a very scary dream.

The following treatment dialogue occurred after Bill presented the above dream. The dialogue was recorded on audio tape and has been modified somewhat for purposes of brevity and to protect Bill's identity and confidentiality. Bill has given permission to utilize the following dialogue in this article:

Therapist (T): Who were the men who left you off on the ninth level? Did you know them? Did you recognize them?
Client (C): No, I didn't know them.
(T): Any feeling about who they might be?
(C): Well, they were from my hometown. It's a coal town, you know. I don't know...maybe my uncles. Yea, probably my uncles. That feels right.
(T): How about the ninth level? What's that about? Any ideas? (The therapist knows that Bill's father died when Bill was nine years old.)
(Long silence)
(T): Any ideas at all?
(C): No...No, not really.
(Silence)
(T): O.K., so let's go back to the coal wall. What does being next to a coal wall mean? What could it mean? Who was the voice? Who comes into mind?
(C): It just now popped into my mind. It's probably my father. He died in a coal mine accident. He died when I was nine. In some ways I've been hoping to hear his voice ever since.
(T): So, any chance getting dropped off on level nine speaks to this?
(C): (Starting to cry) Hell, yes! That's it! Level nine and I lost him when I was nine...God, that's clear!
(Long period when client cries)
(T): So look...these men who dropped you off...maybe your uncles. Like did any of your uncles take you up and give you time after your Dad died? Any of them help you out?
(C): Hell, no!...Hell, no! I was on my own...like they helped Mom out with money and stuff until she could get a job and start working. But hell, no!...My Mom started working and my uncles didn't spend time with me at all. Hell, no!

(T): So, this does not sit well with you...they left you off at level nine. No father, and left off to 'pick' for yourself. (Long silence)
(C): God, yes...s*. I bet it's my father behind the wall. I bet it's his voice.
(Long silence)
(T): Maybe yes...maybe no. Who else could it be? Who else might it be?
(C): Hell, I don't know...nobody. It's got to be my father.
(T): Anyone else you know who lost a father? Anyone else you think it might be?
(Client starts to cry again)
(C): S*! It's my kids behind the wall. You're right. It was a child's voice! God...I'm a workaholic and I don't spend time with my kids. Damn...I'm doing the same thing to them that happened to me. S*!
(Client cries)
(T): Pretty good dream...real good dream...tough talking dream.
(C): Yea...Hell of a dream. I'm becoming dead to my kids. I put them behind a wall...God, I've got to turn this around.
(T): So the meaning potential in the dream is not being a dead man--a dead father to your kids, and the thing you need to do is to...?
(C): Spend time with them...stop being a workaholic! Start being a father!
(T): Start being a father. Maybe take the opportunity your father never got. Do what your dad didn't get to learn to do.
(C): Yeah! That's it. It's a good dream...a tough dream!
(Crying)" (Lantz, 1997; pp. 95-98).

Case 2: "Actualizing in a Dream by Joyce".

"In her sixth logotherapy treatment session, Joyce shared the following dream:

I was in a taxicab. I was going to a job interview. When we got to the office building where I was to be interviewed, I tried to open the taxicab door, but it would not open. I asked the man who was driving the taxi to help, but he told me that he wouldn't help. So...I didn't get the job.

After considerable reflection about this dream, Joyce decided that the dream 'outlined' her long-term pattern of trying to get other people to 'do things for me.' Joyce reported that she was 'especially good' at getting men to 'take care of me' and that she was disappointed because the logotherapist was not overly eager to 'solve all my problems.' Joyce decided that her dream gave her 'permission' to tell the logotherapist about her 'methods of getting by' that she 'might use in therapy.' Joyce and the logotherapist were able to use this dream to reflect upon their relationship, Joyce's consistent and repetitive 'dependency' patterns, and to develop a treatment contract about what was 'Joyce's job' and what was the 'therapist's job.' The dream helped to point out the dependency patterns Joyce used to disrupt her ability to actualize the 'meaning potentials' in her life" (Lantz, 1997; pp. 102-103).

Both Frankl (1975) and Lantz (1997) have noted that the task of the therapist in the analysis of the dreams is to ask patients to interpret key points, in the form of a dialogue, containing **free associations** on the topic, and **Socratic Questioning** about its possible meaning. Good dream analysis either brings out something new to patients or something that they already recognise as true.

Dreams can be used in therapy to facilitate the treatment process; although not all dreams are significant, and therapists should also be careful that the analysis of dreams does not lead to excessive self-observation, fatalistic interpretations, or create unnecessary burden and anxiety for patients.

(6) The Logoanchor Technique:

This technique was developed and described by Dr. Anne Graber-Westermann, in 1993. *Logo-anchor* refers to experiences, images, and events that once filled a person with **wonder** and a sense of **uniqueness**. The method aims at making people aware

of such instances in their **past** for use in the **present**. According to Graber-Westermann (1993) this technique can be used to bridge gaps in communication between partners in couples counselling; to find motivation for living in individual-, and group settings; and to comfort frightened, lonely, and anxious clients.

(7) The Appealing Technique:

The *Appealing Technique* was developed by Dr. Lukas in 1986. She noted that, logotherapeutic techniques might not be applicable in the case of young people, patients who are dependent, unstable, or addicted, and patients who are near collapse, or whose energy level is too weak to carry out a therapy plan with free cooperation.

These conditions, explained Dr. Lukas (1986b), represent instances where the noetic dimension may be temporarily blocked, and the resources of the human spirit are not fully accessible before the blocks are removed.

The essence of the appealing technique is that, regardless of patients' current physical, emotional, and mental abilities, the therapist communicates **trust** in the unlimited **dignity**, **responsibility**, and **meaning-orientation** of the patient. The therapist relays to patients, that although their sense of freedom may be blocked at the present, it can be freed to accomplish self-chosen tasks and goals (Lukas, 1986, 1986b).

For example, in the case of drug addictions, it is not possible to change patients' meaningless paths of self-destruction before they undergo detoxification. As long as they are in the grip of the drugs, their resources of the human spirit are blocked (Lukas, 1986b).

Similarly, in the case of endogenous depression, the treatment should consist primarily of pharmacotherapy and even electro-shock therapy (Frankl, 1993). The role of logotherapy is to make the patient aware of the **good prognosis**, to discourage them from attempting to fight depression with their own will-power, which in this case is not possible, and to help them to learn how to "*...let the waves of depression wash over them*" (Frankl, 1993; p. 67).

As part of the appealing technique, in all cases in which clients try to blame others for their failures, starting their sentences with "**because**," logotherapists can ask them to reformulate their story-line to "**although**" (Guttmann, 1996; p. 133): For example, to say that "*although they were not accepted by their parents as children, they have the capacity to show to themselves, and to others that they can live a decent life*."

(8) The Method of Common Denominators:

This method was first described by Frankl in his book the *Artzliche Seelsorge* ("Medical Ministry,"1965) for helping people make decisions in the case when they are confronted with **equally desirable goals**. To aid the decision making process, the task of the therapist is to project the goals to the level of values, where people can become aware of their own value-hierarchies. The realization of any of the values represents unique, and irrepeatable opportunities. Saying "*yes*" to one value, means saying "*no*" to other values. Thus, upon gaining conscious awareness of the value

hierarchy, patients are invited to consider which value they would like to actualize, depending on which they believe represents a "greater-," or "lesser" good.

Dr. Lukas (1995; p. 135) provided the following case example to illustrate this process:

> A married woman, the mother of two children, called Dr. Lukas late one evening to request help. She said that she was desperate because she was thorn between her commitment to her husband, and a casual relationship with her lover. Reportedly, her husband and her children did not know about her strong attachment to her lover, but she could not go on living without being able to reach a decision about whether to stay with her family, or to leave, and live her lover. The woman stated that she attended many counselling sessions to deal with this issue before, but, unfortunately none of them helped her to reach a decision.
>
> Over the phone, Dr. Lukas proposed to make the following balance sheet of "Common Denominators:" First, "think about how many people would be affected by your decision to leave your husband, and to go and live with your lover." Then, "put the names of all these people in a column, one below the other." The woman listed five people: her husband, her lover, herself, and her two children. Next, Dr. Lukas asked her to think about how each of these people would feel about her decision to leave? In the column next to it, "consider their feelings about your decision to stay, and why they would feel this way?"
>
> Beginning the task, the woman evaluated the feelings of each person, one by one. She said that her husband would be definitely very sad if she left because he loved her very much. Promptly, Dr. Lukas asked her to put a "minus" sign next to her husband's name, under the column "leave;" and a "plus" sign next to her husband's name in the column underneath the heading "stay." Her lover, continued the woman, does not really care. So, Dr. Lukas asked her to put a "plus and a minus" sign next to her lover's name in both columns. "Myself," continued the woman, "don't really know what to do." So, again, Dr. Lukas asked her to put a "plus and a minus" sign next to her name in both columns. "My children would definitely miss me very much" said the woman. Dr. Lukas asked her to put two plus signs next to their names in the column "stay" and two "minus signs" in the column "leave." Then, she asked the woman to add up the pluses and minuses in both columns, across all the names. The total for column "stay" was five pluses, two minuses. The total for column "leave" was two pluses and five minuses.
>
> These "results" indicated that it would be "better" for her to stay. However, Dr. Lukas wanted to refrain from making a value judgment. [Logotherapy teaches that the ultimate decision, and responsibility, always belongs to patients. Without obeying this responsibility, therapists would compromise their freedom, and their dignity to make responsible decisions.] Instead, she said to the woman: "There is only one thing that is left for you to do, and, it concerns a decision that no one else can make instead of you: You have to decide how much pain you want to inflict upon those whom you love." [Alternatively, she could have said: "Only you can decide how much pain you are going to spare from those who you love."] The woman thanked Dr. Lukas. The wisdom that she already knew in her heart reached her conscious awareness (Lukas, 1995; p. 135; cited in Ungar, 1998; p. 220-221).

During a workshop on D*ialogue Forms in Logotherapy*, (Lukas, 2000) the following dilemma was presented to the therapist:

> A wife was thorn between whether to celebrate Christmas visiting her elderly mother, who was living alone, with her husband; or celebrate Christmas with her husband. Reportedly, she felt a commitment to her mother, as she loved her, and her husband loved her mother too. She also loved her husband, dearly. Reportedly, it was custom in their home to celebrate Christmas with her mother each year, but she was longing to celebrate once, alone with her husband, and to make it a special evening for just the two of them. There was also a trip which was a one-time-offer that she and her husband were thinking of booking, which meant that, reportedly, for the first time in the twenty years of their married life, they would celebrate Christmas being away for a week.

> As usual with the method of "Common Denominators," Dr. Lukas asked her what each decision would mean for each of the participants involved: Reportedly, her husband loved her so much that he would not mind to celebrate, as in the years before, even though she suspected that he would like the change. Anyway, her husband was flexible and very understanding of her, and did not impose a decision on her, either way, which, admittedly, made it more difficult for her to come to a decision about what to do. Her mother, as she reported, would have been very happy to see them at Christmas-time as she "always does a lot of preparations, and makes Christmas a big event." Reportedly, the woman's siblings were also always invited to attend. So, her mother would have been sad if they did not come that year. As for herself, the woman reported that she would have felt very happy and excited to celebrate with her husband for the first time, and she would have not enjoyed the celebration with her mother, but would have attended out of a sense of "duty."
>
> Upon hearing this, Dr. Lukas, asked her to think about the real meaning of Christmas. The woman said it was to "share love." "Would it have been truly love that she gave to her mother at Christmas time?" Admittedly, "no"—she would have been resentful, "yet pretend to be happy," and give a gift. "Love is something that can not be demanded"-mused Dr. Lukas, "and the most precious gift…." "Clearly, your resentment would not be in harmony with your sense of the spirit of Christmas, the celebration of love...Would there be any other ways that you could give real love as a gift to your mother?"
>
> The woman came up with this alternative: She can write a card and phone her mother on Christmas Eve, and spend the rest of the time with her husband. Her siblings will visit her mother on that day. She will talk to them over the phone. The next week, after they come back from the holiday, she and her husband will visit her mother.
>
> Upon a second evaluation of who would be affected, and in what ways, the woman could clearly see that "everybody would be happier, at the end." The real advantage, she said is that she could be "guilt free" and not have to pretend. She will be really happy to see her mother, and they can have a long conversation about their trip. Her mother would also be happier to see her happy.

As we see, the method of *Common Denominators* is helpful in avoiding value judgement, or making decisions instead of patients. They can be used to resolve value-conflicts, and to break through those points that traditionally would be dictated by less reflected on "**should**", and "**do-**," and "**don't**" s, which, instead of blindly accepting, patients can evaluate for themselves—are they still meaningful in the light of the moment, or in the light of a greater sense of meaningfulness in life? Many situations are not ideal, but this does not have to prevent us from choosing the best option that is available.

(9) Self-transcendent Questions for Couples:

The "**Meaning-oriented Question Scheme**" was developed by Dr. Lukas in 1997 (Lukas, 1998; Ungar, 1998; Ungar, & Ungar, 2002). It arose form the applications of logotherapy in family practice, where it can be particularly used with couples who demonstrate a, so called, "**burdened communication**" pattern (Lukas, 1997).

Burdened communication, although it is better then when the couple do not talk to each other at all, conceals the same principle; a habitual attitude, or assumption, thoughts, or actions that take the place of honest dialogue, which, instead of misunderstandings, resentments, and suffering for both, could be followed by a response that is helpful, constructive, or appreciative; in other words, caring, and loving for both.

Partners often inadvertently end up causing each other suffering, or a circumstance arises which affects both of them. All other things being equal, there are some core skills that when couples learn them, they are in a better position to resolve conflicts, and sooner find a way out, in a way that is meaningful to them. Some of these ways were presented by Dr. Lukas' *Logotherapy Textbook* under the heading "*Pax and Logos*" (Lukas, 1998; pp. 201-209).

While there are many challenges in married life, and many ways in which partners find a way to support each other, here we are concerned with one particular question-scheme, which can be applied whenever the root of the problems lies in "*burdened communication*," lack of insight, and self-transcendence, and where, although love and commitment of the partners to each other may have suffered, it is essentially, and fundamentally there.

The questioning, which can be done with help from a skilful therapist, or, later, self-monitored by the partners if they "moderate" the dialogue, follows a particular pattern of inquiries through which the partners can shift their focus away from blaming themselves, or each other, for their problems, which they are habitually, or automatically resorting to in stressful situations, and focus instead on what they can do to "*hold each other up*" on their journey together.

During some quiet time to spend with each other, the general "*script*" for the questions is as follows (Lukas, 1997; Ungar, & Ungar, 2002):

Step I: A couple describes a certain conflict situation, which they have gone through without solution. The therapist (or the moderator) summarizes the reported events, and, asks the partners to take some time to reflect on "*What do you think was the actual element that upset your partner the most in this incident?" "What was it that you have said or done, that you are guessing that has caused the most amount of suffering to your partner?"*

Individually, both answer, and the therapist summarizes the responses. [When partners think about their own actions in front of each other, and concisely verbalize their thoughts with help from the therapist, they understand each other better. The effort for self-examination is registered by both, and is welcomed as a valuable resource in the relationship].

After both answered, the therapist cross-checks the responses: *"Is it right what your partner guessed? Is it really true that if he/she did this, it would reduce your suffering in a similar situation?"* Here the therapist mentions the specific guesses by both. If one or both fail to agree, they can correct what they guessed first.

Most couples are very good at intuiting what might have hurt the other person the most. The therapist can pinpoint such insights as positives in the relationship.

Step II: The therapist presents the next question: *"In case if a similar situation occurs again, do you see any possibility to prevent your partner from suffering in this way?" Alternatively, "If a similar situation occurred, what do you think you can do to reduce the amount of suffering of your partner?"* This question is again individually answered.

Subsequently, the therapist cross-checks the responses: *"Would this change of behaviour reduce the amount of suffering you would experience?"* If one or both fail to agree, they are allowed to describe instead what would help them, but they are not allowed to make greater demands. [The therapist occasionally has to stop partners from making unrealistic demands. Also, the suggestions have to be realistic. So, the therapist can ask: *"Is this change what you have guessed really a possibility for you?"*]

Step III: The therapist asks both partners: "*Are you ready to realize the possibility which you mentioned and change your behaviour in a similar situation—independently of what your partner does?"* --This means, if partners are willing to change their own behaviour, independently of the actual success of the other changing their ways next time. Both can say "yes" or "no" to this. If only one person say "yes," this alone can increase hope in the relationship. Although, most couples who have made a realistic and truthful inventory will say "yes" to this question.

Finally, the therapist may ask both: *"Are you happy about the readiness of your partner to change his/her behaviour in a similar situation. Can you accept his/her effort as genuine?"*

While the meaning-oriented question scheme is not a panacea for all the challenges of married life, these challenges are easier handled in a respectful, supportive, authentic, gentle, and caring environment, which is the aim of this exercise to restore, and to uphold.

(10) Frankl's Mountain-range Exercise:

Frankl's "*Mountain range Exercise*" (Ernzen, 1990; p. 133) can be used in individual sessions and in small groups to broaden clients' value base. It was described in the *Doctor and the Soul* (1986), where Frankl invites us to spread our lives before us like a beautiful mountain range. The purpose of the exercise is to invite us to think about "*What we would put on the peaks?" Wouldn't people who touched our lives, or whose life-example we cherish, make all the difference in how we view our life as a whole?*

Participants in group settings can be invited to sketch out their range. They are given opportunity to discuss who appeared on their range; encouraged to look for recurring values, and reflect on the empowerment that they received from these values.

Ernzen (1990) reported the use of this exercise with recovering alcoholics, and psychiatric inpatients (mostly with schizophrenic diagnosis), in order to focus on values of other persons that the participants may have incorporated into their own value system, and occasionally, to help participants realize that there have been positives in their lives.

(11) Literature and Art as Therapeuticum:

In *Man's Search for Meaning*, Frankl recalls that one day, in the concentration camp, a group of young men were destined for a transport to the gas chambers of Auschwitz. Before this transport took off the next morning, interestingly the meagre library of the camp was burglarised and missing were several classics stolen by these men on the death row.

Why some people have been so cruel as to design the Auschwitz concentration camp-, and others like it; and how is it that some prisoners entered the gas chambers with a prayer on their lips? –According to Frankl, ideas, and ideals have been always a part of camp-life, and their influence was more relevant than the availability of bread.

When Frankl's first manuscript was destroyed in the camps, he clearly took this event as a sign to start to live his ideas. He found a leaflet thorn from a prayer book, hidden in the inner lining of a jacket which he inherited from a former inmate, with the principal Jewish prayer, the *Shema Israel,* on it. It became his steady companion.

Later, afflicted with typhoid fever, he scribbled the outline of the *Doctor and the Soul* on discarded paper smuggled by his comrades and presented to him secretly as a birthday-gift.

In 1992, when he was interviewed by Adolf Opel, Frankl remarked that **literature** is very relevant in logotherapy, and especially good literature; poems, stories, and novels which make us think, and inspire us to live our lives to the fullest, or challenge us by presenting alternatives. During this interview Frankl mentioned some if his favourite authors; among them Schnitzler, Verfel, Tolstoy, and Dostoevsky, Joseph Roth (his book "*Job*"), the poet Christine Lavant, as well as other humanistic and existentialist writers.

Current literature shows that logotherapists frequently use literature not only to inspire their patients, or to make them think, but also to gain strength themselves (Ungar, et. al., 2000; Ernzen, 2001; Peden-Levy, 2000; Welter, 2003).

Dr. Lukas (1996) uses **stories** many times with children, but also with adults. Stories are easy to retain, and they can express truths in a humorous, yet, poignant way. Her book "*Wie Leben Gelingen Kann*" ("How Life Can Succeed") is a compilation of thirty short stories with therapeutic implications. She also published a booklet with her own poems, taken from the wisdom of her insights (Lukas, 1997b). A short summary of her logotheraputic aphorisms appeared in the *International Forum for Logotherapy* in 1997c.

Traditionally, stories were told as a vehicle for preserving heritage, and identity. They were shared not only for the sake of recalling important events, or preserving the past, but as a resource for the future generations.

With this in mind, good stories are the ones that have "*morale*;" they connect the past with the present, and link the present with the future in an attempt to warn, exhort, or inspire.

> "One of the remarkable qualities of the story is that it creates space. We can dwell in a story, walk around it, find our own place. The story confronts but does not oppress; the story inspires but does not manipulate. The story invites us to an encounter, a dialog, a mutual sharing (Henry Nouwen, cited in Welter, 1995; p. 79).

When therapists use stories in conversation, it is relevant not only to recall the story, but to ask the person what they think it means to them (Welter, 1995).

Logotherapeutic principles can be combined with **relaxation**, **guided imagery**, **hypnosis**, and **autogenic training**, and many forms of **art** (Hillmann, 2002; Hutzell, & Lantz, 1994; Lantz, 2003; Graber-Westerman, & Madsen, 1994), music therapy (i.e., Zsok, 1998), and with art therapy (i.e., da Silva Prado, 2003).

Art therapy can be especially well combined with logotherapy:

> According to an account, when Dr. Lukas, was teaching in Italy, she was taken to a hospital for the care of AIDS patients. As part of their treatment, patients could choose to participate in art therapy, during which they were given a piece of wooden board, on which they could paint an icon, and will it to someone. Often the icons were willed to individuals in the patients lives with whom there was still "unfinished business," such as parents, friends, or relatives. Other paintings were exhibited locally. The staff members observed that, while the patients were working on the icons, their request for pain medication has dropped by as much as fifty percent. Many patients refused to have pain medication altogether while working on the icons. The medical staff also noted that, to a phenomenal extent, the patients did not die until the task was completed. Once the task was completed and the icons willed to someone, the patients no longer fought death (Lukas, via Barnes, 1995; Punzi, 1993).

Perhaps not many people know that Frankl used art in presenting logotherapy:

In 1945, shortly after his release following three years in Nazi prison camps, Frankl wrote a drama entitled "*Synchronization in Buchenwald*." He recalls, "It was as if something deep inside me dictated the play. I could hardly write fast enough…"

> "In this drama, the Athenian philosopher Socrates (469-399 BC), the Dutch-Jewish philosopher Spinosa (1632-1677), and the German metaphysician Immanuel Kant (1724-1824) join the dead mother of two sons and their fellow sufferers in a concentration camp to grapple with the eternal question first raised by Job: Why do we have to suffer? What is the meaning of an apparently meaningless situation? --Out of the synchronisation of time and space appears an answer which has made Viktor Frankl's contribution to health pre-eminent in today's world" (The Viktor Frankl Institute of Logotherapy, 1999).

POINTS TO PONDER:

* Which among the above described methods appeals most to you?

* Are you aware of other exercises which help to reinforce the will to live A *Life with Meaning*?

Closing Summary:

The present book brings to the reader the principles of logotherapy, a meaning-oriented approach to psychotherapy, and it traces its evolution, and development, from its very early "roots" --as found in the life of Dr. Viktor Frankl--to its "fruits"--the methods and applications first put forth by Dr. Frankl, and elaborated and expanded by other logotherapists, such as my teachers and mentors in logotherapy, Dr. Elisabeth Lukas, and Dr. Robert C. Barnes.

Our review of *Logophilosophy* intended to illustrate the depths to which logotherapy aspires in terms of conceptualizing of human beings as not only existing along the dimensions of body, and psyche, but essentially, as spiritual beings in their particular social and cultural environments.

Through understanding the philosophical, anthropological, and psychotherapeutic foundations of logotherapy, we gradually arrived to the description of the context within which guidance for our lives can be chosen through the search for concrete, personal goals, in harmony with an overarching purpose, and *Ultimate Meaning* for our lives.

Considering the concepts of *Logotherapy* helped us to illustrate the heights, which are possible through a life lived with a sense of purpose, and dignity, and thus, even in the face of suffering, affecting our entire being.

Throughout this text we presented several logotherapeutic techniques, each of which deserves its own place, and role, in meaning-oriented therapy. We also highlighted the elements of the meaning-oriented dialogue, within which context these techniques can be applied with wisdom.

We have demonstrated the ways in which logotherapy can be used either as a *specific therapy*, to respond to a sense of meaninglessness; or within the framework of an eclectic approach, as a *complement* to other forms of interventions.

As we have evidenced, in all the cases presented in this book, logotherapy's effectiveness is principally based on aiding the will to *A Life with Meaning*.

REFERENCES:

VOLUME I--LOGOTHEORY

Introduction:

Estes, K. (1997). Logotherapy in Counsellor Education: Important but Neglected. The International Forum for Logotherapy,20(1), pp. 20-27.

Frankl, V.E. (1984). Man's Search for Meaning. (3rd Ed.). Newly Revised and Enlarged Edition. A Touchstone Book: Simon & Schuster, New York.

Gelman, M. Kosma, L. Wurm, C. & Keks, N. (2000). Images in psychiatry. Viktor Emil Frankl. American Journal of Psychiatry, 157(4), 625.

Kelly, E., Jr., (1994). The Role of Religion and Spirituality in Counsellor Education: A National Survey. Counselor Education and Supervision, 33, 227-237.

Ungar, M. (1999). Viktor E. Frankl's Meaning-oriented Approach to Counselling Psychology. Doctoral Dissertation. The University of Alberta, Edmonton, Canada.

Chapter I: The Life of Dr. Frankl.

Ellenberger, H. F. (1970). The Discovery of the Unconscious. The History and Evolution of Dynamic Psychiatry. New York, NY: Basic Books, Inc.

Estes, K. (1997). Logotherapy in Counsellor Education: Important but Neglected. The International Forum for Logotherapy. 20(1), pp. 20-27.

Fabry, J. (1997). Viktor Frankl 1905-1997. The International Forum for Logotherapy, 20(2). Foreword.

Fabry, J. (1994). "The Beginning of Logotherapy." The Pursuit of Meaning. Berkeley, CA: Institute of Logotherapy Press. Pp. 7-15.

Frankl, V.E. (1984). Man's Search for Meaning. (3rd Ed.). Newly Revised and Enlarged Edition. New York, NY: A Touchstone Book by Simon & Schuster.

Frankl, V. E. (2000). Recollections. An Autobiography. Cambridge, Massechusetts: Perseus Publishing.

Levinson. J. I. (2001). Dr. Frankl's Vita, Achievement, Dedication, Humility. The International Forum for Logotherapy, Vol. 24(2), pp. 102-111.

Opel, A. (1992). Viktor E. Frankl. An Adolf Opel Film. Available from the Viktor Frankl Institute of Logotherapy, USA. Order from: P.O. Box 15211, Abilene, Texas, 79698-15211, U.S.A.

Ungar, M. (1999). Viktor Frankl's Life. Viktor E. Frankl's Meaning-oriented Approach to Counselling Psychology. Doctoral Dissertation. Ottawa, Canada: National Library of Canada [2000]. ISBN: 0612396010. PP. 13-31.

Related Resources and Articles:

Education and Credentialing Program in Logotherapy by the Viktor Frankl Institute of Logotherapy. Edited by Dr. R. C. Barnes (2000). Viktor Frankl Institute of Logotherapy, USA.

Episodes, Anecdotes, and Memories of Viktor Frankl—the teacher, counsellor, and human being. The International Forum for Logotherapy, 21(1).

Frankl Memorabilia and Library, Berkeley, CA. web site: 2400 Ridge Road, Berkeley,CA94709.Ph(+1)-510-649-2507;Fax(+1)-510-649-2508Email: lglenn@gtu.edu

The Official website of the Viktor Frankl Institute Vienna: www.viktorfrankl.org Section on Societies and Activities world-wide. Includes contact addresses all the countries, where there are institutes, study groups, or clinics.

Newsletter of the Viktor Frankl Institute. Fall 1997. Volume 3, Issue 1.

Bodendorfer, L. (1985). Recollections from the Early Days. The International Forum for Logotherapy, 8(1), pp. 5-6

Fabry, J. (1980). Three Faces of Frankl. The International Forum for Logotherapy, 3, 40-41.

Frankl, V. E. (1945). Synchronisation in Buchenwald. A Drama and Staged Play. Manuscript translated by Joseph Fabry. Edited by the Viktor Frankl Institute, Abilene, Texas, in 1997.

Frankl, V. E. (1981). The Future of Logotherapy. The International Forum for Logotherapy, 4(2), 71-78.

Kalmar, S. (1989). Logotherapy and the Holocaust. Responsibilities and Memory Repression. In: W. Fick, M. Davis-Finck, L. D. Larson (Eds.). Pursuit of Meaning: The Road to Self-esteem and Social Coscience. The Proceedings of the Seventh World Congress on Logotherapy. Institute of Logotherapy Press. Berkeley, California.
Klingberg, H. (2001). Viktor and Elly Frankl. Defying the Danube. The International Forum for Logotherapy, 24 (1), pp.35-50.
Leslie, R. C. (1980). Visits to Auschwitz and Dachau. The International Forum for Logotherapy, 3, 43-44.

Chapter II—The Three Pillars of Logotherapy.

(1) Meaning of Life--Logotherapy as Philosophy:

Frankl, V. E. (1967). Psychotherapy and Existentialism. New York, NY: Washington Square Press.
Frankl, V. E. (1972). Der Wille zum Sinn. (The Will to Meaning). Bern: Hans Huber.
Frankl, V. E. (1981). Die Sinnfrage in der Psychotherapie. (The Question of Meaning in Psychotherapy). Munchen:Piper.
Frankl, V. E. (1984). Man's Search for Meaning. A Touchstone Book. Simon & Schuster. New York.
Frankl, V. E. (1984). The Unheard Cry for Meaning. New York, NY: Pocket Books/Simon & Schuster.
Frankl, V. E. (1986). The Doctor and the Soul. New York, NY: Vintage Books.
Frankl, V. E. (1992). Psychotherapie vur der Alltag. (Psychotherapy in Everyday Life) Freiburg. Herder/Spektrum.
Frankl, V. E. (1994). Logotherapy und Existenzanalyse. Munchen:Quintessenz.
Frankl, V. E. (1996). Der Mensch for der Frage nach dem Sinn. Munchen. Piper.
Lukas, E. (1989). Psychologische Vorsorge. (Psychological Ministry). Freiburg. Herder.
Lukas, E. (1995). What is Special About Logotherapy? A Presentation of its Holistic Elements with Case Studies. Unpublished Paper. Read at the Xth World Congress on Logotherapy, Dallas, Texas, July, 1995.
Lukas, E. (1998). Logotherapy Textbook. Toronto, Canada: University of Toronto Press Inc.
Ungar, M. (1999). Viktor E. Frankl's Meaning-oriented Therapy in Counselling Psychology. Doctoral Dissertation. National Library of Canada: Ottawa [2000]; ISBN 0612396010.

Selected "IFL" (The International Forum for Logotherapy) Articles that Relate to this Topic Include:

Dansart, B. (2000). On The New Cosmology and Education for Menaing. The IFL, 23(2), 65-73.
Eisenberg, M. (1986). Logophilosphy as Preventive Therapy. The IFL, 9(1), pp. 23-28.
Gould, W. B. (1987). Scheler's 'Philosophy of the Heart' and Frankl's Understanding of the Self. The IFL, 10(2), pp. 118-123.
Gould, W. B. (1988). Comparison of Socrates and Frankl. The IFL, 11(2), pp. 122-123.
Kovacs, G. (1985). Viktor Frankl's "Place" in Philosophy. The IFL, 8(1), pp. 17-21.
Lantz, J. (1995). Frankl and Marcel: Two Prophets of Hope for the 21st Century. The IFL, 18(2), pp, 65-68.
Lantz, J. (2000). Heidegger's Brightness and Frankl's Self-Transcendence. The IFL, 23(2), 81-88.
Sappington, A. A., Bryant, J., & Oden, C. (1990). An Experimental Investigation of Viktor Frankl's Theory of Meaningfulness in Life. The IFL, 13(2), pp125-130.

(2) Freedom of Will—Anthropological Foundations of Logotherapy:

Barnes, R. C. (1995). Logotherapy's Consideration of the Dignity and Uniqueness of The Human Person, Unpublished Manuscript. Hardin-Simmons University, Abilene, Texas.
Fabry, J. (1994). The Pursuit of Meaning. (newly Revised Ed.). Institute of Logotherapy Press: Abilene, Texas, U.S.A.
Frankl, V. E. (1975). Der Anthropologische Grundlagen der Psychotherapie. (The Anthropological Foundations of Psychotherapy). Hans Huber: Vienna.
Frankl, V. E. (1984). Man's Search for Meaning. A Touchstone Book. Simon & Schuster. New York.
Frankl, V. E. (1986). The Doctor and the Soul. New York, NY: Vintage Books.

Frankl, V. E. (1988). The Will to Meaning. Foundations and Applications of Logotherapy. Meridian, Penguin: New York.
Frankl, V. E. (1991). Psychotherapie in der Praxis (Psychotherapy in Practice, 2nd Ed.). Munchen: Piper GmBH & Co.
Frankl, V. E. (1992). Psychotherapie vur der Alltag (General Psychotherapy; 4th Ed.) Freiburg: Herder/Spektrum.
Frankl, V. E. (1993). Theorie und Therapie der Neurosen (Theory and Therapy of Neuroses; 7th Ed.). Munchen: Reinhardt.
Frankl, V. E. (1994). Logotherapy und Existenzanalyse. (Logotherapy and Existential Analysis). Munchen:Quintessenz
Frankl, V. E. (1996). Der Mensch for der Frage nach dem Sinn. (Confronted with the Question of Meaning). Munchen. Piper.
Lukas, E. (1986). Meaning in Suffering. Institute of Logotherapy Press. Berkeley, CA.
Lukas, E. (1998). Logotherapy Textbook. Toronto, Canada: University of Toronto Press Inc.
Mendez, M., Mendez, E., & Ungar, J. (2003). Transcendental Locus of Control—Is it Akin to Noodynamics? Paper in Press. The IFL. Submitted: January, 2003.
Stanich, J. (1995). Neotic and Psychic Dimensions in Clinical Practice and Research. The IFL, 18(2), 97-101.
Ungar, M. (1999). Viktor E. Frankl's Meaning-oriented Therapy in Counselling Psychology. Doctoral Dissertation. National Library of Canada: Ottawa [2000]; ISBN 0612396010.

Related Resources:

Fabry, J. (1994). The Pursuit of Meaning. Institute of Logotherapy Press; Berkeley, CA. Pages: 20-27.
Lynn, Carol (1981). The Disabled and the Authentic Self. The IFL, 4(2), 126-128.
Uffelman, H. W. (1989). Caring: The Ethical Imperative of the Healing Arts and Sciences. The IFL, 12(2), 66-73.

(3) The Will to Meaning—Logotherapy as a Theory of Psychotherapy:

Abrami, L. M. (1997). Conversations with Terminally Ill Patients, The IFL, 20 (2), 80-85.
Barnes, R. (1995). Logotherapy and the Human Spirit. Unpublished Manuscript. Hardin-Simmons University, Abilene, Texas.
Boschemeyer, U. (1989). Logotherapeutic Approaches to Crisis Situations. The IFL, 12(1), pp. 17-22.
Frankl, V. E. (1972). Der Wille zum Sinn (The Will to Meaning). Vienna, Austria: Hans Huber.
Frankl, V. E. (1975). Der Anthropologische Grundlagen der Psychotherapie (Anthropological Foundations of Logotherapy). Hans Huber: Vienna
Frankl, (1984). Psychotherapy and Existentialism. New York, NY: Simon and Schuster, Inc.
Frankl, (1984b). The Unheard Cry for Meaning. New York, NY: Simon and Schuster, Inc.
Frankl, V. E. (1986). The Doctor and The Soul. From Psychotherapy to Logotherapy. Revised and Expanded edition. New York, NY: Random House Publishers.
Freeman, S.J. (1995). Crisis Intervention and Logotherapy: A Case Study. The IFL, 18(2), pp. 114-115.
Giovinco, G. (1994). Logotherapy: A Journey Into Meaning for People with AIDS, The IFL, 17(2), pp. 76-81.
Haines, P. E. (1986). Reviving the Shattered Spirit. The Missing Link in Rehabilitation. The IFL, 9(2). pp. 112-115.
Lantz, J. (1984). Responsibility and Meaning in the Treatment of Schizophrenics. The IFL, 7(1), pp. 26-28.
Lazar, E. (1984). Logotherapeutic Support Groups for Cardiac Patients. The IFL, 7(2), pp. 85-97.
Long, J. (1982). A Journey Into Meaning. The IFL, 5(1), 57-58.
Long, J. (1997). Logotherapeutic Trascendental Crisis Intervention. The IFL, 20(2), 104-112.
Long, J. (2000). Physician Assisted Suicide: A Choice Against Meaning. The IFL, 23(1), 5-13.
Long, J. (2003). The Gift: A Cherished Labor of Love. The IFL, 26(2), 74-80.
Lukas, E. (1993). Logotherapeutic Crisis Intervention: A Case History. The IFL, 16(1), 51-54.
Lukas, E. (1998). Logotherapy Textbook. Toronto, Canada: University of Toronto Press Inc.
Simms, G.R. (1979). Logotherapy in Medical Practice. The IFL, 2(2),12-14.
Sjolie, I. (2002). A Logotherapists view of Somatization Disorder and a Protocol. The IFL, 25(1) 24-30.
Stefanics, C. (1989). Logotherapy and Nursing Practice. The IFL, 12(2), 97-100.

Ungar, M. (1999). Viktor E. Frankl's Meaning-oriented Therapy in Counselling Psychology. Doctoral Dissertation. National Library of Canada: Ottawa [2000]; ISBN 0612396010.
Ungar, M. (2002). A Logotherapy Treatment Protocol for Major Depressive Disorder. The IFL, 25(1) 3-10.

Related Resources:

Lukas, E. (1987). Logotherapy: Health Through Meaning. The IFL, 10(1) 9-16.
Yoder, J. C. (1989). Logotherapy as Homecoming. The IFL, 12(2) 74-81.

Chapter III: Concepts in Logotherapy.

Abrami, L. M. (2001). The Twelve Step Program and the Search for Meaning. The IFL, 24(2), 65-67.
Addad, M., & Leslau, A. (1989). Moral Judgement and Meaning in Life. The IFL, 12(2), 110-115.
Barnes, R. C. (1995). Logotherapy and the Human Spirit. Unpublished Manuscript. Hardin-Simmons University, Abilene, Texas, U.S.A.
Barnes, R. C. (1995b). Logotherapy's Consideration of the Dignity and Uniqueness of the Human Person. Unpublished Manuscript. Hardin-Simmons University, Abilene, Texas, U.S.A.
Barnes, R.C. (1995c). Viktor Frankl's Logotherapy. Unpublished Manuscript. Hardin-Simmons University, Abilene, Texas, U.S.A.
Barnes, D. C. (2002). Logotherapy's Consideration of Morality, Values, and Conscience. The IFL, 25(2), 102-110.
Berti, G., & Schneider-Berti, A. (1994). When an Offspring Dies: Logotherapy in Bereavment Groups. The IFL, 17(2), 65-68.
Boschemeyer, U. (1982). Logogeriatrics. The IFL, 5(1), 9-15.
Eger, E. E. (1986). Personal Conscience and Global Concern. The IFL, 9(2), 86-70.
Fabry, J. (1979). The Noetic Unconscious. The IFL, 2(2), 8-11.
Fabry, J. (1994). The Pursuit of Meaning. (newly Revised Ed.). Institute of Logotherapy Press: Abilene, Texas, U.S.A.
Fabry, J., & Lukas, E. (1995). Auf den Spuren des Logos. Briefwchsel mit Viktor E. Frankl ("The Traces of Logos. Correspondence with Viktor E. Frankl"). Quintessens, Munchen.
Frankl, V. E. (1965). Man's Search for Meaning.: Washington Square Press: New York, NY.
Frankl, V. E. (1967). Psychotherapy and Existentialism, Selected Papers on Logotherapy. Washington Square Press/ Pocket Books: New York, NY.
Frankl, V. E. (1969). The Will to Meaning. Washington Square Press: New York, NY.
Frankl, V. E. (1972). Der Wille Zum Sinn (The Will to Meaning). Hans Huber Verlag: Bern.
Frankl, V. E. (1975). Der Anthropologische Grundlagen der Psychotherapie. Hans Huber: Vienna.
Frankl, V. E. (1981). Die Sinnfrage in der Psychotherapie. (The Question of Meaning in Psychotherapy). Piper: Munchen.
Frankl, V. E. (1984). Man's Search for Meaning. (Revised and Enlarged Ed.). Washington Square Press: New York, NY.
Frankl, V. E. (1984b). The Unheard Cry for Meaning. Psychotherapy and Humanism.: Washington Square Press/Pocket Books: New York, NY.
Frankl, V. E. (1994). Logotherapy und Existenzanalyse. Quintessenz: Munchen.
Frankl, V. E. (1996). Zeiten der Entscheidung. (Times of Decision). Herder/Spektrum: Freiburg.
Frankl, V. E. (1996b). Der Mensch for der Frage nach dem Sinn. (Facing the Question of Meaning, 8th Ed.). Piper: Munchen.
Giovinco, G. McDougald, J. (1994). Logotherapy: A Journey Into Meaning for People with AIDS. The IFL, 17(2), 76-81.
Guttman, D. (1996). Logotherapy for the Helping Professional. Meaningful Social Work. Springer Publishing Co.: New York, NY.
Haines, P. (1986). Reviwing the Shattered Spirit: Missing Link in Rehabilitation. The IFL, 9(2), 112-115.
Harris-Pergam. M. (1989). Support Group for Mothers of Handicapped Children. The IFL, 12(1), 23-27.
Henrion, R. (1987). Making Logotherapy a Reality in the Treatment of Alcoholics. The IFL, 10(2), 112-117.
Henrion, R. (2002). Alcohol Use Disorder: Alcohol Dependence. The IFL, 25(1), 30-38.

Hooper, R. I., Walling, M. K., & Joslyn, W. D. (1996). Logotherapeutic Principles in the Treatment of Panic Attacks with Agoraphobia: A Case History. The IFL, 19(2), 95-99.
Hutchinson, G. (2002). A Logotherapeutic Approach to the Treatment of Obessive Compulsive Disorder. The IFL, 25(1), 46-51.
Hutzell, R. (1984). Logoanalysis for Alcoholics. The IFL, 7(1), 40-45.
Hutzell, R. R., Gonzalez-Forestier, T. & Eggert-Jerkins, M. (1991). Multiple Personality Disorder and Logotherapy. The IFL, 14(1), 11-21.
Kass, J. (1996). Coping with Life Threatening Illness Using a Logotherapeutic Approach—Stage I: Health Care Team Interventions. The IFL, 25(1), 15-19.
Kass, J. (1996b). Coping with Coping with Life Threatening Illness Using a Logotherapeutic Approach—Stage II: Clinical Mental Health Counselling. The IFL, 19(2), 113-118.
Khatami, M. (1987). Logotherapy for Chronic Pain. The IFL, 10(2), 85-91.
Kimble, M. A., & Ellor, J. W. (1989). Use of Meaning with the Elderly. The IFL, 12(1), 59-61.
Lantz, J. (1984). Responsibility and Meaning in the Treatment of Schizophrenics. The IFL, 7(1), 26-28.
Lantz, J. & Lantz, J. (1994). Franklian Treatment with Traumatised Families. The IFL, 17(1), 20-26.
Lantz, J. (1998). Logotherapy with Chrinic Physical Illness Clients. The IFL, 21(2), 78-84.
Lantz, J., & Lantz, J. (2001). Trauma Therapy: A Meaning Centred Approach. The IFL, 24(2), 68-76.
Lazar, E. (1984). Logotherapeutic Support Groups for Cardiac Patients. The IFL, 7(2), 85-88.
Leslie, R. C. (1982). Counselling the Aged. The IFL, 5(1), 47-52.
Lukas, E. (1983). Counselling Tactics and Personality Structure. The IFL, 6(1), 3-18.
Lukas, E. (1984). Human Dignity and Psychotherapy. The IFL, 7(2), 67-84.
Lukas, E. (1985). The Meaning of Logotherapy for Clinical Psychology. The IFL, 8, 7-10.
Lukas, E. (1987). Logotherapy: Health Through Meaning. The IFL, 10(1), 9-16.
Lukas, E. (1989). Psychologische Vorsorge. (Psychological Ministry). Herder Verlag: Freiburg.
Lukas, E. (1995). Psychological Ministry. Unpublished Manuscript. Translated from the original "Psychologische Vorsorge" by Weltrand Schulte.
Lukas, E. (1998). Logotherapy Textbook. University of Toronto Press Inc.: Toronto, Canada.
Lukas, E. (2000). Personal Communication. Fuerstenfeldbruck, Germany.
Lynn, C. (1981). The Disabled and the Authentic Self. The IFL, 4(2), 126-128.
Maniacek, M. A. (1982). Logotherapy: A Grief Counselling Process. The IFL, 5(2), 85-91.
Morrison, E. E. (1999). Integrating Logotherapy Into a Course in Ethics. The IFL, 22(1), 44-47.
Olive, K. W. (1990). Meaning in Drug Treatment. The IFL, 13(2), 131-132.
Pacciola, A. (1993). The Unconscious Spirituality, Religiosity, and Morality. Journal des Viktor Frankl Institutes, An International Journal for Logotherapy and Existential Analysis. 1(2), 89-96.
Rogina, J. (2002). Logotherapeutic Mastery of Generalised Anxiety Disorder. The IFL, 25(1), 60-67.
Russell, B. (1996). History of Western Philosophy. Routledge, London, U.K.
Simms, G. R. (1979). Logotherapy in Medical Practice. The IFL, 2(2), 12-14.
Starck, P. (1981). Rehabilitative Nursing and Logotherapy. The IFL, 4(2), 101-109.
Stavros, M. (1991). Logotherapy and the Disabled. The IFL, 14(1), 26-31.
Takashima, H. (1987). Three Sacred Treasures and the Rehumanisation of Medicine. The IFL, 10(1), 42-43.
Uffelman, H. W. (1989). Caring: The Ethical Imperative of the Healing Arts and Sciences. The IFL, 12(2), 66-72.
Ungar, M. (2002). A Logotherapy Treatment Protocol for Major Depressive Disorder. The IFL, 25(1), pp. 3-10.
Van Pelt, I. (1994). The Meaning of Chronic Headache—The Role of the Human Spirit in Conflict Resolution. The IFL, 17(2), 70-75.
Wawrythko, S. (1989). The Meaning of the Moment. The IFL, 12(2), 117-123.
Yalom, I. D. (1982). The 'Terrestrial' Meanings of Life. The IFL, 5(2), 92-102.

Chapter IV: Existential Dynamics and Existential Analysis.

Barnes, R. C. (1995). Logotherapy and the Human Spirit. Unpublished Manuscript. Department of Counselling and Human Development, Hardin-Simmons University, Abilene, Texas.
Barnes, R. C. (1995b). Alfred Adler's Individual Psychology. Unpublished Manuscript. Department of Counselling and Human Development, Hardin-Simmons University, Abilene, Texas.
Crumbaugh, J. C., & Maholick, L. T. (1969). Manual of Instructions for the Purpose in Life Test. Psychometric Affiliates: Murfreesboro, TN.

Crumbaugh, J. C. (1977). Seeking of Noetic Goals Test. Manual of Instructions. Psychometric Affiliates: Munster Indiana.
Fabry, J. (1994). The Pursuit of Meaning. (Newly Revised Ed.). Institute of Logotherapy Press: Abilene, Texas, U.S.A.
Frankl, V. E. (1965). Man's Search for Meaning. Washington Square Press: New York, NY.
Frankl, V. E. (1967). Psychotherapy and Existentialism, Selected Papers on Logotherapy. Washington Square Press/ Pocket Books: New York, NY.
Frankl, V. E. (1972). Der Wille Zum Sinn (The Will to Meaning). Hans Huber Verlag: Bern.
Frankl, V. E. (1975). Der Anthropologische Grundlagen der Psychotherapie. Hans Huber: Vienna.
Frankl, V. E. (1984). Man's Search for Meaning. (Revised and Enlarged Ed.). Washington Square Press: New York, NY.
Frankl, V. E. (1984b). The Unheard Cry for Meaning. Psychotherapy and Humanism.: Washington Square Press/Pocket Books: New York, NY.
Frankl, V. E. (1992). Psychotherapie vur der Alltag. (General Psychotherapy; 4th Ed.). Herder/Spektrum: Freiburg.
Frankl, V. E. (1994). Logotherapy und Existenzanalyse. Quintessenz: Munchen.
Frankl, V. E. (1996). Zeiten der Entscheidung. (Times of Decision). Herder/Spektrum: Freiburg.
Lukas, E. (1989). Logotherapy Textbook. University of Toronto Press Inc.: Toronto, Canada.
Russell, B. (1996). History of Western Philosophy. Routledge, London, U.K.

Related Resources:

Crumbaugh, J. C., & Henrion, R. (1988). PIL Test: Administration, Interpretation, Uses; Theory and Critique. The IFL, 11(2), 76-88.
Fabry, J. (1993). The Credit Card Syndrome. In: M. Davis-Finck, & T. Gilmore-Finck (Eds.). Viktor Frankl and Logotherapy. Everything to Gain. Proceedings of the Eight World Congress of Logotherapy held at San Jose, California. Institute of Logotherapy Press, Saratoga, CA.
Frankl, V. E. (1984). The Meaning Crisis in the First World and Hunger in the Third World. The IFL, 7(1), 5-7.
Guttman, D. & Cohen, B. (1993). On the Relationship Between Meaning in Life and Excessive Behaviours Among the Active Elderly in Israel. Journal des Viktor-Frankl-Instituts, 1(2) Fall, 38-55.
Hutzell, R. R. (1988). Review of the PIL Test. The IFL, 11(2), 89-101.
Kisch, G. B. & Moody, D. R. (1989). Psychopathology and Life Purpose. The IFL, 12(1), 40-45.
Lantz, J. (1987). Schizophrenia and the Existential Vacuum. The IFL, 10(1), 17-21.
Lantz, J. (1989). The Existential Vacuum in 'Scenes form a Marriage.' The IFL, 12(1), 57-58.
Levinson, J. I. (1989). Existential Vacuum in Grieving Widows. The IFL, 12(2), 101-109.
Pintos. C. G. (1993). What is Behind Depression Among the Elderly? Logotherapy and the Treatment of Geriatric Depression. Journal des Viktor-Frankl-Instituts, 1(2) Fall, 27-37.
Rahman, T. (2001). Mental Health and Purpose in Life of Drug Addicts in Bangladesh. The IFL, 24(2), 83-87.
Rodriguez, R. (2001). Noodynamisms of Value-deficiencies. The IFL, 24(1), 30-34.
Rutkowski, T. (1993). Excessive Gambling—Masking a Frustrated Will to Meaning? The IFL, 16(2), 97-102.
Sands, R. (1986). The Encounter with Meaninglessness. The IFL, 9(2), 102-108.
Sappington, A. A., Bryant, J., & Oden, C. (1990). Investigation in Frankl's Theory of Meaningfulness of Life. The IFL, 13(2), 125-130.
Sappington, A. A., & Kelly, P. J. (1995). Purpose in Life and Self-Perceived Anger Problems Among College Graduates. The IFL, 18(2), 74-82.
Shek, D. T. (1994). Meaning in Life and Adjustment Among Midlife Patients in Hong Kong. The IFL, 17(2), 102-106.
Shek, D. T. (1999). Meaning in Life and Adjustment Among Early Adolescents in Hong Kong. The IFL, 22(1), 36-43.
Siroky, V. (1983). Treatment of Existential Frustration. The IFL, 6(1), 40-41.
Sjolie, I. (2001). A Homeopath Looks at Somatic Manifestation of Noogenic Neuroses. The IFL, 24(1), 10-12.
Stecker, R. E. (1981). The Existential Vacuum in Eastern Europe. The IFL, 4(2), 79-82.
Wolicki, M. (1987). Despair—An 'Absolutization' of Values. The IFL, 10(1), 50-51.

VOLUME II—LOGOTHERAPY

Chapter V: The General Process of Logotherapy.

Asagba, R. B. (1996). The Pursuit of Democracy in Nigeria. The IFL, 19(2), 91-94.
Berens. A. (2003). A Quest for Meaning Workshop. The IFL, 26(1), 11-14.
Berti, G., & Schneider-Berti. A. (1994). When an Offspring Dies; Logotherapy in Bereavement Groups. The IFL, 17(2), 65-68.
Boshemeyer, U. (1982). Logogeraitrics. The IFL, 5(1), 9-15.
Crumbaugh, J. C. (1988). Everything to Gain. A Guide to Self-Fulfilment Through Logoanalysis. Institute of Logotherapy Press. Berkeley, CA.
Dansart, B. R. (1993). Logophilosophy; Compass for an Embattled Education. The IFL, 16(2), 89-96.
Eisenberg, M. (1979). Applications in Groups: Intergenerational Communication. The IFL, 2(2), 23-24.
Eisenberg, M. (1996). The Death of a Logotherapist. The IFL, 19(1), 39-40.
Ernzen, F. (1997). Teaching Children Peace Making Skills. The IFL, 20(2) 77-79.
Estes, K. & Welter, P. (1994). The University Department as a Base for Promoting The Study and Practice of Logotherapy. The IFL, 17(1) 27-31.
Frankl, V. E. (1984). The Meaning-Crisis in the First World, and Hunger in the Third World. The IFL, 7(1), 5-7.
Harris, W. M. (2001). Language and Self-Distancing. The IFL, 24(1), 16-19.
Hirsch, B. (1994). Logotherapy in School Crisis Situation. The IFL, 17(2), 82-86.
Hirsch, B. & Kalmar, S. S. (1982). Logotherapy in US Universities. A Survey. The IFL, 5(2), 103-105.
Hoppe, H. N. (1989). Logotherapy in Schools. The IFL, 12(1), 12-16.
Jilek, W., & Jilek-Aall, L. (1986). A Melanesian Quest for Meaning. The IFL, 9(2), 87-92.
Kalmar, S. S. (1982). What Logotherapy can Learn from High School Students? The IFL, 5(2), 77-84.
Kanahara, S. (2001). School Avoidance and Logotherapy in Japan. The IFL, 24(1), 25-29.
Klitzke, L. L. (1981). Logotherapy in Tanzania. The IFL, 4(2), 83-88.
Ko, Byung-Hak (1981). Applications in Korea. The IFL, 4(2), 89-93.
Lantz, J. (1984). Growth Stages in Logotherapy. The IFL, 7(2), 118-120.
Lantz. J. (1984b). The Noetic Curative factor in Group Therapy. The IFL, 7(2), 121-125.
Lantz. J. (1987). Franklian Family Therapy. The IFL, 10(1), 22-28.
Lantz, J. (1993). Treatment Modalities in Logotherapy. The IFL, 16(2), 65-73.
Lantz. J. (1996). Stages and Treatment Activities in Family Logotherapy. The IFL, 19(1), 20-23.
Lantz, J., & First, R. (1987). Family Treatment and the Noetic Curative Factor. The IFL, 10(2), 110-111.
Lantz. J., & Harper, K. (1991). Self-transcendence in Marital Therapy. The IFL, 14(1), 50-52.
Lantz, J. & Lantz, J. (1994). Franklian Treatment with Traumatised Families. The IFL, 17(1), 14-19.
Lazar, E. (1984). Logotherapeutic Support Groups for Cardiac Patients. The IFL, 7(2), 85-88.
Leslie, R. (1982). Counseling the Aged. The IFL, 5(1), 47-52.
Lieban-Kalmar, V. (1979). Groups for Dyslexic Adolescents. The IFL, 2(2), 28-30.
Lukas, E. (1985). The Meaning of Logotherapy for Clinical psychology. The IFL, 8(1), 7-10.
Lukas, E. (1986). Youth—A Continuous Search for Meaning. The IFL, 9(2), 71-79.
Lukas, E. (2000). Dialogue Forms In Logotherapy. Intensive Seminar and Workshop held at the South German Institute of Logotherapy. Furstenfeldbruck, Germany. December, 2000.
Martinez Romero, J. V. (1988). Group Therapy in Latin America. The IFL, 11(2), 102-106.
McLafferty, Jr. C. (2003). Integration of Logotherapy Into a Lifespan Human Development Course. The IFL, 26(2), 95-101.
Millul, G. (2003). From Hostility to Co-existence Through Meaning: A Possible Reality in a Multi-cultural World. The IFL, 26(2), 81-94.
Moore, C. (1998). The Use of the Visible Metaphor in Logotherapy. The IFL, 21(2), 85-90.
Mori, H. (1991). Lessons from Two Children. The IFL, 14(1) 46-48.
Pergam, M. H. (1989). Suport Groups for Mothers of Handicapped Children. The IFL, 12(1), 23-27.
Pintos, G. (1993). What is behind the Depression in the Elderly? Logotherapy and the Treatment of Geriatric Depression. Journal des Viktor Frankl Instituts. 2, 27-36.
Rahman, T. (2001). Mental Health and Purpose in Life of Drug Addicts in Bangladesh. The IFL, 24(2), 83-87.
Rice, G. (2000). An Optimistic Stance Toward Disruptive Behavior. The IFL, 23(1), 30-39.
Rife, J. C. (1990). Meaning and the Older Unemployed Worker. The IFL, 13(2), 119-124.

Salthouse. A. (2003). Noguera's Respect program: A Logotherapeutic Approach to Youth Violence. The IFL, 26(1), 44-48.
Schulenberg, S. E. (2002). Logotherapy and Conduct Disorder. The IFL, 25(1), 52-59.
Sibaja-Makai, D. (1979). Logotherapy Groups in Prisons. The IFL, 2(2), 25-27.
Starck, P. (1985). Logotherapy: A Critical Component of Modern Nursing. The IFL, 8(1), 41-43.
Starck, P. (2003). Meaning-Centered Leadership in Health Care. The IFL, 26(2), 110-113.
Stecker, R. E. (1981). The Existential Vacuum in Eastern Europe. The IFL, 4(2), 79-83.
Stecker, R. E. (1985). The Promise of Logotherapy in the Socialist World. The IFL, 8(1), 57-60.
Stefanics, C. (1996). Experience with Logotherapy; Nursing the Elderly. The IFL, 19(1), 34-38.
Troyer, H. (1986). Logotherapy and the Amish: Meaning and the Maintenance of a Traditional Society. The IFL, 9(1), 47-53.
Welter, P. (1994). The Element of Surprise in the Logotherapeutic Treatment of Adolescents. The IFL, 17(1), 8-13.
Whiddon, M. (1983). Logotherapy in Prison. The IFL, 6(1), 34-39.
Wintz, C. (1997). Nurse Structuring of a Logotherapeutic Milieu for Schizophrenic Inpatients. The IFL, 20(1), 11-19.
Wright, M. W. (1996). "A New Course for Management" Revisited. The IFL, 19(1), 29-33.
Yoder, J. (1983). A Child, Paradoxical Intention, and Consciousness. The IFL, 6(1), 19-21.

Chapter VI: Logotherapeutic Intervention.

(1) The Diagnostic Phase:

Diagnostic and Statistical Manual of Mental Disorders. (Fourth Edition; 1994). American Psychiatric Association. Washington.
Frankl, V. E. (1993). Theorie und Therapie der Neurosen. (Theory and Therapy of Neuroses). Reinhardt: Munchen.
ICD-10 Classification of Mental and behavioural Disorders (1992). Clinical Descriptions and Diagnostic Guidelines. WHO: Geneva.
Lukas, E. (1986). Meaning in Suffering. Comfort in Crisis Through Logotherapy. Institute of Logotherapy Press. Berkeley, CA.
Lukas, E. (1998). Logotherapy Textbook. University of Toronto Press. Toronto, Ontario.
Ungar, M. (1999). Viktor E. Frankl's Meaning-oriented Therapy in Counselling Psychology. Doctoral Dissertation. National Library of Canada: Ottawa.

Related Resources:

Harris, W. M. (2001). Language and Self-Distancing. The IFL, 24(1), 16-19.
Lukas, E. (1979). The "Ideal Logotherapist—Three Contradictions. The IFL, 2(2), 3-7.
Lukas, E. (1999). "Key Words" as a Guarantee Against The Imposition of Values by the Therapist, The IFL, 22(1), 1-7.
Lukas, E. (1998). "Dialogue Forms in Logotherapy" (Chapter). Logotherapy Textbook. University of Toronto Press. Toronto, Ontario.
Lukas, E. (1998). "Classifying Neurosis According to Viktor E. Frankl." (Chapter). Logotherapy Textbook. University of Toronto Press. Toronto, Ontario.
Ungar, M. (1999). "Principles of Meaning-oriented Therapy." (Chapter). Viktor E. Frankl's Meaning-oriented Therapy in Counselling Psychology. Doctoral Dissertation. National Library of Canada: Ottawa.

(2) The Therapy Phase:

Barnes, R. C. (1995). Logotherapy and the Human Spirit. Unpublished Manuscript. Department of Counselling and Human Development, Hardin-Simmons University, Abilene, Texas.
Barnes, R. C. (1995b). Viktor Frankl's Logotherapy. Unpublished Manuscript. Department of Counselling and Human Development, Hardin-Simmons University, Abilene, TX.
Boschemeyer, U. (1989). Logotheraputic Approaches to Crisis Situations. The IFL, 12(1), 17-22.
Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition; 1994). American Psychiatric Association. Washington, DC, U.S.A.

Eisenberg, M. (1982). Logotherapy; Prescription for Survival: "From the Bitter Came Forth the Sweet." The IFL, 5(2), 67-71.
Eisenberg, M. (2000). Life Review and Life Preview. The IFL, 23(1), 24-29.
Ernzen, F. I. (1986). Discerning Meaning Through a Self-Discovery Program. The IFL, 9(1), 54-56.
Fabry, J. (1968). The Pursuit of Meaning. Viktor Frankl, Logotherapy, and Life. Preface by Viktor E. Frankl. Beacon Press, Boston, MA.
Fabry, J. (1994). The Pursuit of Meaning. (New Revised Ed.) Institute of Logotherapy Press: Abilene, Texas.
Frankl, V. E. (1952). The Pleasure principle and Sexual neurosis. The International Journal of Sexology, 5, 128-130.
Frankl, V. E. (1962). Man's Search for Meaning. An Introduction to Logotherapy. A Revised and Enlarged Edition of From Death camp to Existentialism (preface by Gordon Allport). A Touchstone Book: New York, NY.
Frankl, V. E. (1965). Man's Search for Meaning. An Introduction to Logotherapy. (Original Title: From Death camp to Existentialism). Pocket Books: New York, NY.
Frankl, V. E. (1965b). Artzliche Seelsorge (Medical Ministry; 7th Ed.). Deuticke: Vienna, Austria.
Frankl, V. E. (1984). The Unheard Cry for Meaning. Psychotherapy and Humanism. Washington Square Press/ Pocket Books: New York, NY.
Frankl, V. E. (1984b). Man's Search for Meaning. An Introduction to Logotherapy. Newly Revised and Enlarged, Third Edition. A Touchstone Book by Simon & Schuster: New York, NY.
Frankl, V. E. (1986). The Doctor and the Soul. Vintage Books: New York, NY.
Frankl, V. E. (1996). Zeiten der Entscheidung (Times of Decision). Herder/Spektrum: Freiburg, Germany.
Freeman, S. J. (1995). Crisis Intervention and Logotherapy: A Case Study. The IFL, 18(2), 114-115.
Hutzell, R. R., & Jerkins, M. E. (1995). A Wokbook to Increase Your Meaningful and Purposeful Goals (MPGs; Revised Ed.). Library of Congress Cataloguing-in-Publication Data ISBN 0-917867-10-6. U.S.A.
Khatami, M. (1988). Clinical Application of the Logochart. The IFL, 11(2), 67-75.
Lantz, J. & Greenlee, R. (1990). Logotherapy and the Vietnam Veteran. The IFL, 13(2), 115-118.
Lantz, J., & Lantz, J. (2001). Trauma Therapy: A Meaning Centered Approach. The IFL, 24(2), 68-76.
Lantz, J. & Lantz, J. (1994). Franklian Treatment with Traumatised Families. The IFL, 17(1), 14-19.
Long, J. (2000). Physician-assisted Suicide—A Choice Against Meaning. The IFL, 23(1), 5-13.
Long, J. (1993). Logotheraputic Crisis Intervention. In: Viktor Frankl and Logotherapy: Everything to Gain. Proceedings of the VIII World Congress of Logotherapy. Marx Davies-Finck, M. & Gilmore-Finck, T. (Eds.). Institute of Logotherapy Press, Saratoga, CA.
Lukas, E. (1972). Zur Validierung der Logotherapie. (Validating Logotherapy), in V. E. Frankl (Ed.). Der Wille zum Sinn (The Will to Meaning). Hans Huber Verlag: Bern, Germany.
Lukas, E. (1981). Validation of Logotherapy. The IFL, 4(2), 116-125.
Lukas, E. (1984). Meaningful Living. Grove Press, New York, NY.
Lukas, E. (1984b). Human Dignity and Psychotherapy. The IFL, 7(2), 67-84.
Lukas, E. (1986). Meaning in Suffering. Comfort in Crisis Through Logotherapy. Institute of Logotherapy Press, Berkeley, CA.
Lukas, E. (1993). Logotherapeutic Crisis Intervention: A Case History. The IFL, 16(1), 51-54.
Lukas, E. (1994). Psychotherapie in Wurde: Sinnorientierte lebenshilfe nach Viktor E. Frankl. (Psychotherapy with Dignity: Viktor E. Frank's Meaning-oriented Approach). Quintessenz: Munchen, Germany.
Lukas, E. (1996). Logotherapy in Crisis Prevention. Workshop. Held at the OISE/UT, University of Toronto, Ontario, Canada, November, 1996.
Lukas, E. (1998). Logotherapy Textbook. Translated by Theodor Brugger. Liberty Press, Toronto, Ontario, Canada.
Lukas, E. (2000). Crisis Intervention. Workshop. Presented at the South German Institute of Logotherapy. December, 2000. Fuerstenfeldbruck, Germany.
Sahakian. W. S. (1986). Logodrama and Philosophical Psychotherapy. The IFL, 9(1), 33-39.
Salthouse, A. (1993). Staying Alive: A Logotherapeutic Approach to Suicide Prevention. In: Viktor Frankl and Logotherapy: Everything to Gain. Proceedings of the VIII World Congress of Logotherapy. Marx Davies-Finck, M. & Gilmore-Finck, T. (Eds.). Institute of Logotherapy Press, Saratoga, CA.
Stavros, M. (1991). Logotherapy and the Disabled. The IFL, 14(1), 26-31.

Ungar, J., Hodgins, D., & Ungar, M. (1997). Purpose in Life and Alcoholic Recovery: A Correlational Study. Paper Submitted for Publication in the International Forum for Logotherapy. November, 1997.
Ungar, J., Hodgins, D., & Ungar, M. (1997). Purpose, Goals, and Alcoholic Recovery. The IFL, 21(2), 72-77.
Ungar, M. (1996). The Nature of Counselling Relationships from the Perspective of Logotherapy. The IFL, 19(2), 119-121.
Ungar, M. (1997). A Four-Step Model of Logotherapy. The IFL, 20(2), 113-119.
Ungar, M. (1999). Viktor E. Frankl's Meaning-oriented Therapy in Counselling Psychology. Doctoral Dissertation. National Library of Canada: Ottawa.
Ungar, M. (2002). A Logotherapeutic Treatment protocol for Major Depressive Disorder. The IFL, 25(1), 3-10.
Ward, P. (1990). A Journey of Self-Discovery. The IFL, 13(2), 97-100.
Wilson, R. (1995). Combining Frankl's Logotherapy with a Holistic Wellness Model. Unpublished Manuscript. Presented at the International Congress on Logotherapy, Dallas, Texas, 1995.

(3) Follow-up Phase:

Lukas, E. (1986). Meaning in Suffering. Comfort in Crisis Through Logotherapy. The Institute of Logotherapy Press. Berkeley, CA.
Lukas, E. (1996). Logotherapy in Crisis Prevention. Unpublished Workshop Notes. Workshop held at OISE/UT, Toronto, Ontario. November, 1996.

Chapter VII: Specific Logotherapeutic Techniques.

Abrami, L. M. (1997). Conversations with Terminally Ill Patients. The IFL, 20(2), 80-84.
Ascher, L. M. (1980). Paradoxical Intention, Viewed by a Behavior Therapist. The IFL, 3, 13-16.
Atlas, A. J. (1984). Logotherapy and the Book of Job. The IFL, 7(1), 29-33.
Barnes, R. (1993). Finding Meaning in Unavoidable Suffering. Journal des Viktor Frankl Instituts. Vol. 1(2) 14-21.
Barnes, R. C. (1993). Finding Meaning in Unavoidable Suffering. Journal des Viktor Frankl Instituts. An International Journal of Logotherapy and Existential Analysis. 1(2), 14-21.
Bazzi, T. (1979). Paradoxical Intention and Autogenic Training. The IFL, 2(2), 35-37.
Berti, G., & Schneider-Berti. A. (1994). When an Offspring Dies: Logotherapy in Bereavement Groups. The IFL, 17(2), 65-68.
Bulka, R. P. (1984). Logotherapy as an Answer to Burnout. The IFL, 7(1), 8-17.
Bulka, R. P. (1989). Jewish Humor—A Logotherapeutic Tool of Survival. In: The Pursuit of Meaning; The Road to Self-esteem and Social Conscience. Proceedings of the Seventh World Congress of Logotherapy. W. Finck, M. Davis-Finck, & L. D. Larson (Eds.). Institute of Logotherapy Press. Berkeley, CA.
Coetzer, P. H. (1992). Gratefulness: A highway to Meaning? The IFL, 15, 104-107.
Crumbaugh, J. C., Wood, W. M., & Wood, C. W. (1980). Logotherapy: New Help for Problem Drinkers. Nelson-Hall, Chicago, U.S.A.
Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition; 1994). American Psychiatric Association. Washington, DC, U.S.A.
Eisenberg, M. (1982). Logotherapy: Prescription for Survival "From the Bitter Came Forth the Sweet." The IFL, 5(2), 67-72.
Fabry, J. (1982). Some Practical Hints About Paradoxical Intention. The IFL, 5(1), 25-30.
Fabry, J. (1994). The Pursuit of Meaning. Institute of Logotherapy Press, Berkeley, CA.
Frankl, V. E. (1952). The Pleasure Principle and Sexual Neurosis. The International Journal of Sexology, 5, 128-130.
Frankl, V. E. (1962). Man's Search for Meaning. An Introduction to Logotherapy. A revised and enlarged edition of From Death Camp to Existentialism (preface by Gordon Allport). A Touchstone Book, New York, NY.
Frankl, V. E. (1965). Man's Search for Meaning. Washington Square press, New York, NY.
Frankl, V. E. (1975). The Unconscious God. Psychotherapy and Theology. Simon, & Schuster, New York, NY.
Frankl, V. E. (1978). The Unheard Cry for Meaning. Washington Square Press, New York, NY.

Frankl, V. E. (1984). Man's Search for Meaning. Revised and enlarged edition. Washington Square Press, New York, NY.
Frankl, V. E. (1984b). The Unheard Cry for Meaning. Psychotherapy and Humanism. Washington Square press/ Pocket Books. New York, NY.
Frankl, V. E. (1985). Conversation with Dr. Richard Evans. University of Toronto Video Production. (Limited circulation copy, available from the Institute of Logotherapy, Dallas, Texas).
Frankl, V. E. (1986). The Doctor and the Soul. Vintage Books, New York, NY.
Frankl, V. E. (1986b). The Doctor and the Soul. Revised And Expanded. Vintage Books by Random House. New York, NY. Pages 105-116.
Frankl, V. E. (1993). Theorie und Therapie der Neurosen. (Theory and Therapy of Neuroses; 7th Edition). Reinhardt; Munchen.
Frankl, V. E. (1994). Logotherapie und Existenzanalyse. Texte Auch Sechs Jahrzenten. (Logotherapy and Existential Analysis. Texts from Six Decades). Quintessenz: Munchen, Germany.
Frankl, V. E. (2000). Guilt: Words to a Man of Death Row. The IFL, 23(1), 47-49.
Guttmann, D. (1996). Logotherapy for the Helping Professional. Meaningful Social Work. Springer Publishing Co., New York, NY.
Haines, P. E. (2000). Logotherapy's Concept Applied to Grief and Mourning. The IFL, 23(2), 74-80.
Heines, K. D. (1997). Experiences with Logotherapy and Existential Analysis in a Hospital for Psychiatry, Psychotherapy, and Neurology. The IFL, 20(1), 4-10.
Henrion, R. (1987). Making Logotherapy a Reality in the Treatment of Alcoholics. The IFL, 10, 112-117.
Hooper, R. I., Walling, M. K., & Joslyn, W.D.(1996). Panic Attacks with Agoraphobia: A Case History. The IFL, 19(2), 95-99.
Jindal, R. D., Buysse, D. J., & Thase, M. E. (2004). Maintenance Treatment of Insomnia: What Can We Learn From the Depression Literature? The American Journal of Psychiatry, 16(1), 19-24.
Khatami, M. (1987). Logotherapy for Chronic Pain. The IFL, 11, 67-75.
Khatami, M. (1995). Existential Therapy for Chronic Pain. The IFL, 18(1), 13-18.
Kovacs, G. (1982). The Question of Death In Logotherapy. The IFL, 5(1), 3-8.
Lantz, J. E. (1982). De-reflection in Family Therapy with Schizophrenic Patients. The IFL, 5(2), 119-122.
Leslie, G. (1994). Frankl's Case of Elfriede G. The IFL, 17(2), 114-120.
Lukas, E. (1979). The "Ideal" Logotherapist: Three Contradictions. The IFL, 2(2), 3-7.
Lukas, E. (1980). Modification of Attitudes. The IFL, 3, 25-34.
Lukas, E. (1981). New Ways for De-reflection. The IFL, 4, 13-28.
Lukas, E. (1982). The "Birthmarks" of Paradoxical Intention. The IFL, 5(1), 20-24.
Lukas, E. (1986). Meaning in Suffering. Comfort in Crisis Through Logotherapy. The In statute of Logotherapy Press. Berkeley, CA.
Lukas, E. (1987). Gesinnung und Gesundheit (Meaning and Health). Herder Publisher: Freiburg, Germany.
Lukas, E. (1990). Overcoming the Tragic Triad. The IFL, 13(2), 89-96.
Lukas, E. (1996). Logotherapy in Crisis-prevention. Unpublished Lecture Notes. Workshop held at the OISE/UT, Toronto, Ontario, November, 1996.
Lukas, E. (1998). Logotherapy Textbook. Translated by Theodor Brugger. Liberty Press, Toronto, Ontario, Canada.
Mendez, E., & Mendez, M. (2003). A Meaning-oriented Frameowrk for Obtaining Consent for Treatment. Paper in Press. The IFL, Submitted: November, 2003.
Paden-Levy, D. (2003). Funny is Serious; Serious is Funny—Humour and Logotherapy. The IFL, 26(1), 15-20.
Schaughnessy, M. F. (1984). Humour in Logotherapy. The IFL, 7(2), 106-111.
Schulenberg, S. (2001). Saying 'Thank You:' On the Role of Gratitude in Logotherapy. The IFL, 24(1), 20-24.
Shantall, T. (1998). A Phenomenological Analysis of Suffering. The IFL, 21(2), 111-120.
Sternig, P. J. (1984). Finding Meaning through Existential Guilt. The IFL, 7(1), 46-49.
Woliczki, M. (1987). Despair—An "Absolutization" of Values. The IFL, 10(1) 50-51.
Yoder, J. D. (1983). A Child, Paradoxical Intention, and Consciousness. The IFL, 6(1), 19-21.
Yoder, J. D. (1994). Paradoxical Intention. The Case of Ron. The IFL, 17(2), 108-113.

Chapter VIII: Narrative Logotherapy.

Barnes, R. C. (1994). Finding Meaning in Unavoidable Suffering. The IFL, 17(1), 20-26.

Fabry, J. (1988). Guideposts to Meaning. Institute of Logotherapy Press. Berkeley, CA.

Fabry, J. (1994). The Pursuit of Meaning. (New, Revised Ed.) Institute of Logotherapy Press, Abilene, Texas.

Frankl, V. E. (1967). Psychotherapy and Existentialism. Pocket Books, Washington Square Press, A Division of Simon & Schuster, New York, NY.

Frankl, V. E. (1975). Unconscious God. Psychotherapy and Theology. Simon & Schuster, new York, NY.

Frankl, V. E. (1984). Man's Search for Meaning. An Introduction to Logotherapy. Newly Revised and Enlarged, Third Edition. A Touchstone Book, Simon & Schuster, New York, NY.

Frankl, V. E. (1986). The Doctor and the Soul. Revised and Expanded. Second Vintage Books Edition. A Division of Random House. New York, NY.

Gould, W. B. (1988). Comparison Socrates and Frankl. The IFL, 11(2), 122-123.

Graber, A. V., & Madsen, M. (1994). Images of Transformation. Two Audio Tapes, available from: Second Glance Production-Audio Div., 12842 3rd Ave. S, Seattle, WA 98168, U.S.A.

Guttmann, D. (1996). Logotherapy for the Helping Professional. Meaningful Social Work. Springer Publishing Co., New York, NY.

Lukas, E. (1986). Meaning in Suffering. Institute of Logotherapy Press, Berkeley, California.

Lukas, E. (1994). Alles Fugt Sich und Erfullt Sich. ("Towards Connection and Completion") The Question of Meaning in Old Age. Quell, Stuttgart, Germany.

Lukas, E. (1999). "Key Words" As a Guarantee Against the Imposition of Values by the Therapist. The IFL, 22(1), 1-7.

Lukas, E. (2000). Logotherapeutic Dialogue Forms. Workshop. Presented at the South German Institute for Logotherapy, Fuerstenfeldbruck, Germany.

Moore, C. (1998). The Use of the Visible Metaphor in Logotherapy. The IFL, 21(2), 85-90.

Moore, C. (2002). Cracking the Meaning Code Through the Visible Metaphor. The IFL, 25(2), 89-95.

Padesky, C. A. (1995). Clinician's Guide to Mind Over Mood. The Guidford Press: New York, NY.

Pintos, C. G. (1993). What is Behind the Depression Among the Elderly? Logotherapy and the Treatment of geriatric Depression. Journal des Viktor Frankl Instituts, 1(2), 27-37.

Scraper, R. (2000). The Art and Science of Maieutic Questioning within the Socratic Method. The IFL, 23(1), 14-16.

Takashima, H. (1990). Humanistic and Psychosomatic Medicine. The Institute of Logotherapy Press. Berkeley, CA.

Welter, P. (1987). Counselling and the Search for Meaning. Word Books: Waco, Texas.

Wilson, R. A. (1995). Socratic Dialogue. Questions That Enhance the Search for Meaning. Unpublished Manuscript. Presented at the Fresno Pacific College for Individual and Group Process. Fresno, CA.

Wilson, R. A. (1997). Finding Meaning Through Frankl's Socratic Dialogue and Fromm's Five Needs of the Human Condition: A Group Process for School Counselling. The IFL, 20(1), 28-36.

Chapter IX: Other Methods in Logotherapy.

Abrami, L. M. (1997). Conversations with Terminally Ill Patients. The IFL, 20(2), 80-85.

Abrami, L. M. (2001). The Twelve Step-program and the Search for Meaning. The IFL, 24(2), 65-67.

Barnes, R. (1995). Logotherapy's Consideration of the Dignity and Uniqueness of the Human Spirit. Unpublished Manuscript. Dept. of COHD, Hardin-Simmons University, Abilene, Texas.

Bulka, R. (1980). Frankl's Impact on Jewish Life and Thought. The IFL, 3, 41-42.

Chakravati, S. S. (1987). Hinduism and Logotherapy. The IFL, 10(1), 44-45.

De Silva Prado, M. (2003). Painting a Dialogue. Presentation at the Fourteenth World Congress on Logotherapy. Dallas, Texas. June 27, 2003.

Eisenberg, M. (1985). Rehumanising University Teaching. The IFL, 8(1), 44-46.

Eisenberg, M. (2000). Life Review and Life Preview. The IFL, 23(1), 24-29.

Ernzen, F. (1990). Frankl's Mountain-range Exercise. The IFL, 13(2), 133-134.

Ernzen, F. (2001). Healing and Growing as a Logotherapist. The IFL, 24(1), 13-15.

Fabry, J. (1989). Logotherapy and Dream Analysis: Dreams as a Royal Road to the Spiritual Unconscious. In: Pursuit of Meaning—The Road to Self-esteem and Social Conscience. Proceedings of the Seventh World Congress of Logotherapy. W. C. Finck, M. Davis-Finck, & L. D. Larson (Eds.). The Institute of Logotherapy Press, Berkeley, CA.

Frankl, V. E. (1945). Synchroisation in Buchenwald. A Drama and Stage Production. Script re-printed and circulated by the Viktor Institute of Logotherapy, Abilene, Texas.

Frankl, V. E. (1965). Artzliche Seelsorge (Medical Ministry; 7th Edition). Deuticke, Vienna, Austria.

Frankl, V. E. (1967). Psychotherapy and Existentialism. Selected papers on Logotherapy. Washington Square Press/Pocket Books: New York, NY.

Frankl, V. E. (1975). Unconscious God. Psychotherapy and Theology. Simon & Schuster, New York, NY.

Frankl, V. E. (1986). The Doctor and the Soul. Revised and Expanded. Second Vintage Books Edition. A Division of Random House. New York, NY.

Frankl, V. E. (1993). Theorie und Therapie der Neurosen. (Theory and Therapy of Neuroses; 7th Edition). Reinhardt; Munchen.

Graber-Westerman, A. (1993). The Logoanchor Technique. The IFL, 16(1), 26-30.

Graber, A. V., & Madsen, M. (1994). Images of Transformation. Two Audio Tapes, available from: Second Glance Production-Audio Div., 12842 3rd Ave. S, Seattle, WA 98168, U.S.A.

Guttmann, D. (1996). Logotherapy for the Helping Professional. Meaningful Social Work. Springer Publishing Co., New York, NY.

Hillmann, M. (2002). Autogenic Training and Logotherapy. The IFL, 25(2), 73-82.

Hutzell, R., & Lantz, J. (1994). The Uses of Hypnosis in Logotherapy. The IFL, 17(2), 87-92.

Khatami, M. (1988). Clinical Applications of the Logochart. The IFL, 11(2), 67-75.

Khatami, M., Doke, D., & Boyer, R. (1990). A Logotherapy and Cognitive Therapy Centre in Dallas. The IFL, 13(2), 83-88.

Kimble, M. A. (1979). Applications in Pastoral Psychology. The IFL, 2(2), 31-34.

Lantz, J. (1997). Reflection, Meaning, and Dreams. The IFL, 20(2), 95-103.

Lantz, J. (2003). Understanding Benefits of the Martial Arts from the Standpoint of Logotherapy. The IFL, 26(1), 1-6.

Lukas, E. (1984). Human Dignity and Psychotherapy. The IFL, 7(2), 67-84.

Lukas, E. (1986). Meaning in Suffering. Institute of Logoterapy Press, Berkeley, California.

Lukas, E. (1986b). Von Der Trotzmacht des Geistes (The Defiant Power of the Human Spirit). Herder, Freiburg, Germany.

Lukas, E. (1995). Psychological Ministry. Manuscript of the English Translation of the book "Psychologische Seelsorge," translated by Weltrand Schulte. Available form the Viktor Frankl Institute of Logotherapy, Abilene, U.S.A.

Lukas, E. (1995b). Logotherapy Lived. Workshop. Presented at the Tenth World Congress on Logotherapy. Dallas, Texas, U.S.A.

Lukas, E. (1996). Wie Leben Gelingen Kann. 30(31) Geschichten mit logotherapeutischer Heilkraft. ("How to Live a Satisfying Life: 30(31) Stories with Logotherapeutic Wisdom). Quell Verlad, Stuttgart, Germany.

Lukas, E. (1997). Meaning-oriented Family Therapy. Workshop. Presented at the Eleventh World Congress on Logotherapy, Dallas, Texas.

Lukas, E. (1997b). Meaningful Lines. Limited Edition. Translated from the German by Bianca Hirsch and Joseph Fabry. Available form the Viktor Frankl Institute of Logotherapy, Abilene, TX.

Lukas, E. (1997c). Logotherapeutic Aphorisms. The IFL, 20(1), 53.

Lukas, E. (1998). Logotherapy Textbook. Translated by Theodore Brugger. Liberty Press, Toronto, Ontario, Canada.

Lukas, E. (1998b). Spiritualle Psychologie (Spirituality in Psychology). Kosel Verlag, Munchen, Germany.

Lukas, E. (2000). Logotherapeutic Dialogue Forms. Workshop. Presented at the South German Institute for Logotherapy, Fuerstenfeldbruck, Germany.

Opel, A. (1992). Interview with Viktor Frankl. Limited Circulation Video Production. Available through the Viktor Frankl Institute of Logotherapy. Abilene, Texas.

Pacciola, A. (1993). The Unconscious in Religiosity, Spirituality, and Morality. Journal des Viktor Frankl Instituts. Vol. 1(2), 89-96.

Paden-Levy, D. (2000). Finding Logotherapy in Today's Popular Culture. The IFL, 23(2), 95-100.

Punzi, I. (1993). AIDS—A Challenge to Logotherapy. Journal des Viktor Frankl Instituts. 1(2), 7-13.

Scraper, R. (2002). Helping People find Meaning in Life. In: The Power of the Human Spirit. C.

Stefanics, and R. Henrion (Eds.). Joseph Publishing Company, Library of Congress Cataloguing in Publishing Data, U.S.A.

Shahakian, W. S. (1985). Logodrama and Philosophical Psychotherapy. The IFL, 9(1), 33-39.

Takashima, H. (1985). Logotherapy and Buddhistic Thought. The IFL, 8(1), 54-56.

Thompson, Y. (1987). A Question of Meaning: Rabbinical Counselling and Logotherapeutic Models. The IFL, 10(1), 29-34.

Ungar, M. (1999). Viktor E. Frankl's Meaning-oriented Therapy in Counselling Psychology. Doctoral Dissertation. National Library of Canada: Ottawa.

Ungar, M., MacKey, L., Guest, M. & Bernard, C. (2000). Logotherapeutic Guidelines for Therapists Self-Care. The IFL, 23(2), 89-94.

Ungar, M. & Ungar, P. (2002). On the Use of Meaning-oriented Questioning with Couples. In: The Power of the Human Spirit. C. Stfanics, and R. Henrion (Eds.). Joseph Publishing Company, Library of Congress Cataloguing in Publishing Data, U.S.A.

Van Pelt, I. (1994). The Meaning of Chronic Headache: The Role of the Human Spirit in Conflict Resolution. The IFL, 17(2), 70-75.

Welter, P. (1995). Logotherapy. Intermediate A. Franklian Psychology and Logotherapy. Textbook Adapted for Distance Education by Dr. Anne Graber. The Viktor Frankl Institute of Logotherapy, Abilene, Texas.

Welter, P. (2003). Logotherapy and Quiet Epiphanies. The IFL, 26(2), 65-73.

Welter, P., & Hutzell, R. (1995). The Movie Experience. In: Logotherapy. Intermediate A. Franklian Psychology and Logotherapy. Textbook Adapted for Distance Education by Dr. Anne Graber. The Viktor Frankl Institute of Logotherapy, Abilene, Texas.

Zsok, O. (1998). Musik und Transsendenz ("Music and Transcendence. A Philosophical Contribution for Understanding the Spiritual Contents in the Gregorian Music, Bach, Beethoven, and Mozart"). EOS, Sankt Ottilien.

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