A PSYCHOLOGIST'S REPLY TO EMILY SCANLAN

In her recent article in SAM ('On My Mind', Issue 3, Sem 1, 2016), psychologist Emily Scanlan expresses a hope that existential therapies will "gain traction" in clinical practice. She suggests that "training in philosophy–based questions" should be included in postgraduate clinical course work, asserting that "many psychologists make it through to registration without substantial training in philosophy-based questions around meaning and purpose. This can mean that clinical psychologists are maybe too careful of going beyond the bounds of what is measurable and statistically valid. Yet this is exactly where the existential client needs to go."

I argue that, conversely, existentialism's tenets and concepts are pernicious to psychotherapy because of their fundamentally anti-scientific nature, and I present my objections here in reply.

Ms Scanlan illustrates her point regarding the special needs of the 'existential client' (a category she estimates represents ten percent of her private practice)[1] by presenting a recent case of a client dogged by the thought, "I don't belong here." In line with existentialist orthodoxy, Ms Scanlan interprets that he "wants to find meaning in his life or give up on it altogether". She states that "(I)n the clinical setting, most clients are helped…by cognitive behaviour therapy (CBT) techniques that seek to name mental processes so they can be considered and treated. Here, my client might be said to have a tendency towards catastrophising and negativity bias./But for the client in the desert, labelling his thinking in this way would be a further degradation in a world where he already feels misunderstood. His desire to understand the point of his life is real, not a glitch in his brain". She concludes her article by revealing her intentions to him that she will accompany him on his journey towards a meaningful life, and that, "(S)lowly but surely there will be shoots and soft green leaves and sprays of colour and you will find yourself waking up in a place you want to be in".

Hidden among these blandishments, however, are several assumptions that implicitly blur the distinction between personal growth coaching/counselling and psychological treatment[2] - such as, for example, that existential approaches can be consistently applied to both the 'worried well' and the clinically/psychiatrically disturbed; that existential 'categories' are more sensitive to the inner life of the patient/client than current DSM classifications; that the insertion of the label 'existential client' into clinical discourse is somehow less reductive and objectifying than current diagnostic categories (or is an adequate substitute for them); and that highly-trained and experienced clinicians lack the competencies to adapt evidence-based counselling approaches to 'non-clinical' problems, or even a

[1] A link to Emily Scanlan's private practice is provided at the conclusion of her article.

[2] Counselling modalities are distinguished from clinical approaches in both training requirements and professional focus. Whereas counselling assists clients with understanding and resolving everyday problems affecting their lives, the focus of clinical psychology (a regulated industry) is the evidence-based treatment of psychological or psychiatric disorders. See http://www.acu.edu.au/about_acu/faculties,_institutes_and_centres/health_sciences/school_of_psychology/whats_the_difference_between_psychology_and_counselling

personal capacity for empathy without invoking existential metaphors

In specifically recommending existential approaches to *clinical* practice, questions are begged as to how this may be practically achieved: how is existential psychology to be considered capable of *augmenting* existing clinical approaches while simultaneously claiming exemption from empirical investigation? Where is its complementary point of integration? Are the *verbal communications* of the 'existential client' at assessment sufficient to justify the epithet 'existential client'? How is a philosophical inquiry into a client's world-view (e.g. about not finding a point to their lives) to be deemed more than empathic listening? In other words, how is 'therapeutic' defined, and how is its effectiveness measured?

Aside from its putative merits as a supportive counselling approach or adjunct therapy (e.g. in fostering personal responsibility, optimism, self-actualization, 'mindfulness', acceptance, reflective listening in establishing rapport, and so on), existential psychotherapy has not moved beyond fringe status among mainstream clinical interventions, primarily due to its theoretical limitations - the most salient being its *relativism* (dismissed as unproblematic by Ms Scanlan), *constructivism*, and programmatic *rejection of determinism*. Existentialism's circuitous path from its theological origins through more recent 'atheistic' and literary accounts to its current 'psychological' versions has not resulted in a re-examination of these limitations over the decades; indeed, its failure to attain empirical status in psychology – arguably the result of its conceptual and theoretical limitations - appears to have reached a critical point that is prompting moves towards a radical reappraisal in the US.[3]

Given the dearth of outcome studies in existential-humanistic therapies, what has fundamentally changed about these modalities that now justifies therapists "going beyond the bounds of what is measurable and statistically valid"? [4]

A brief recap of some of its basic concepts may clarify why existentialism remains on the periphery of evidence-based clinical practice.

According to Irvin Yalom, "existential psychology attempts to explain how ordinary humans come to terms with the basic facts of life with which we all must contend…such as death, freedom, existential isolation, and meaninglessness." These fundamental concerns of existence are "deep, potentially terrifying issues" which, while exerting their influences upon all humanity, most people avoid confronting. Yalom drills down to existentialism's essence: the crisis of meaninglessness "stems from the dilemma of a meaning-seeking creature who is thrown into a universe that has no meaning". [5] For the existentialist, an individual's Being is confronted with an array of universal 'ultimate concerns' and 'existential facts of life' with which he or she must contend. Human consciousness constructs the apprehended world, and the individual strives for meaning within a meaningless universe. Exempting existentialism from the charge of relativism, Ms Scanlan waves aside a century of psychological theory and research: "nothing is for certain and meaning is what you make of it".

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[3]Mascaro and Rosen (2005) notwithstanding. See Dias, J.(2010) Existential systemic therapy. (Doctoral dissertation). Proquest.

[4] http://www.academia.edu/1843926/Existential-Humanistic_Therapy_as_a_Model_for_Evidence-Based_Practice?auto=download. Curiously, this paper excludes the well-being of the client from its list of benefits for existential-humanist therapy as an evidence-based modality.

[5] Handbook of Experimental Existential Psychology, Greenberg, J., Koole, Sander L., & Pyszczynski, T. Eds. 2004

An objectively verifiable, causal model of mental life (such as a biologically-driven, internally conflicted, or even psychotic individual[6]) is antithetical to existential psychology, which views the self or 'spirit' as having a 'being' distinct from ordinary physical objects, and 'meaning' as constructed by human perception – dimensions thus removed from the explanatory categories of the natural sciences.[7] The problem of unconscious processes and psychological conflict is dispensed with by invoking the profounder 'psychic' dimensions of existentialism's universal givens (with which an individual's 'world-design' – *Dasein* - may be in conflict). With 'existential' dilemmas eliding psychological conflict, an authentic 'Dasein' is identified as the goal of therapy – a 'journey' that, via the individual's unique capacity for self-creation and accompanied by the therapist, will assist the 'existential client' to achieve 'authenticity' and 'freedom', and acceptance of the immutable, dreaded laws of existence.

Existential psychotherapy continues to characterise some psychology practice. In the words of another Sydney practitioner, whose existential specialty is a "passion", '(T)he existential-phenomenological approach is about how we each uniquely interpret and make meaning of self, others and the world. *There is no definitive method or particular set of skills. Each practitioner develops their own distinctive perspective and continues to learn, be challenged - and rewarded - along the way. The focus is on the client's experience of their world rather than a reliance on external theories, tools or specific techniques, with the relationship between practitioner and client paramount.*'[8]

But what does this prioritizing of the therapeutic relationship mean? How is the relationship between therapist and client conceptually distinguished (or 'privileged') when all humanity is subject to existentialism's fundamental postulates?[9] What assurances can be made with respect to the psychological well-being of the client under such arbitrary and freewheeling therapeutic conditions?

The failure of therapeutic detachment (or other significant weakening of therapeutic boundaries), for instance, may tip therapists from appropriate empathy into shared subjectivity. Yet the phenomenological requirement to 'enter into' a client's subjective experience is *procedural* in existential psychology, and presents a risk of therapist/client mergence without properly formulated distancing constructs. Existential psychotherapy fails to take into proper account the perennial risk of unconscious (but observable in behaviour) positive or negative transference/countertransference feelings and behaviours being 'acted in' by the psychologist during this 'intuitive' process, risking the integrity of the therapeutic relationship and the well-Being of the client.[10]

Unconscious processes are both pervasive and elusive to conscious awareness (i.e. articulation, identification and interpretation) of both therapist and client in clinical practice. An individual may

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[6] "The individual we deem "schizophrenic" or "psychotic" is merely caught in a profound wrestling match with the very same core existential dilemmas with which we all must struggle". Paris Williams, Ph.D, 2012

[7] Maze, J.R. The Meaning of Behaviour, Allen & Unwin, 1983

[8] My italics. See http://www.cep.net.au/about_us.html

[9] Maze, 1983

[10] i.e., 'transference'/'countertransference' phenomena. Explanation is occasionally sought from psychoanalysis to compensate for the theoretical shortfall. See Zafirides, 2013.

be overwhelmed, for example, by previously suppressed or dissociated memories in response to 'triggering' by stimuli sufficiently similar to a prior traumatic event. In this complex stimulus/ response situation, neither the mechanisms involved in the original suppression of overwhelming stimuli nor its after-suppressions are conscious (although subsequent avoidant behaviour may be), and the client will be highly defended against the (usually) unmanageable feelings and behaviours associated with them. While it is a truism that a depressed, hollowed-out life constantly in retreat from the terrors of unpredictable environmental 'triggering' may ultimately be 'felt' as meaningless and characterized by despair, this characterization barely encapsulates the devastation wrought, in some sense, by an *excess* of meaning.

For the clinician, feelings and beliefs associated with a presenting problem will be noted as *symptoms* or *symbolic communications* reported and/or observed during a clinical assessment conducted according to standardized procedures. A client's communications about needing to 'find meaning' in life is therefore not apprehended as a literal brief; many hypotheses will be considered and explored with the client as to what this crisis might *causally* refer to, beginning with the reformulation of questions pertaining to feelings and beliefs within an evidence-based model of mental life that presumes the existence of a meaningful, relational object *for whom* efforts to do the right thing feel pointless (for example), or *for whom* one believes/feels one has no meaning or value, no matter how virtuous or altruistic his endeavours (for example).

How the complexity and range of an individual clinical presentation can be 'explained' by an array of universals faced by all humanity is a question for existential therapists that will not go away easily, and certainly not by fiat.[11] The notion that clinical disorders are variations of *la condition humane* is reminiscent of recent humanistic anti-psychiatric and social constructionist discourses, and Ms Scanlan's suggestion that clinicians may inappropriately label the 'existential client' with specific symptom features is consistent with these ideological stances. In this fashion, however, Ms Scanlan merely repeats the offence she seeks to counter by advocating a reductionistic 'labelling' process that is moored to a metaphysical system whose fundamental principles cannot be intelligibly expressed in psychological terms, let alone survive empirical test.

Nor is it clear how evidence-based clinical interventions, grounded in the scientific method explicitly repudiated by existentialism, could be enhanced by a therapeutic approach whose concepts ('authenticity', 'agency', 'free will', 'true self', and so on) continue to resist translation into "something we can conceive of in a coherent, graspable way".[12] With its programmatic repudiation of an objective basis to reality (relativism), and its notion of a self consisting solely in its relatedness to its environment – that is to say, having no intrinsic properties, yet nonetheless capable of willing itself into being at every moment (constructivism) - a more explicit repudiation of a scientific psychology would be hard to find. Yet according to Ms Scanlan "existentialism can, in some cases, both complement and deepen other treatment models".

Attempts to "bridge" evidence-based clinical approaches with existential therapies are destined to fail without a logically coherent explanatory framework capable of invigorating its concepts.[13] Existentialism cannot evade its theoretical inadequacies by borrowing from elsewhere when the clinical facts don't fit. Existential frameworks offer little in the way of effecting enduring

[11] Maze, p 126

[12] op cit, p . 128

[13] In his attempts to formalize and existential systemic therapy, Dias (2010) noted that a major problem with investigating existential therapy was the lack of a coherent theory on which to base such an investigation.

psychological change in clinical practice - and for this reason clinicians are best advised to reconsider the inclination to "embrace these ideas and include them more easily in their practice". Although an observationally rich seam that contributes to our fund of knowledge, the clinical setting is not an experimental laboratory but a privileged space - where the safety of the client and the integrity of the therapeutic relationship are the only absolutes.

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