

## THE EXISTENTIAL WAY TO RECOVERY

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### SUMMARY

*This paper explores the essential features of recovery and the need for an existential approach in psychiatry. The biopsychosocial model often fails to sufficiently validate the existential suffering of patients. We review the major principles of recovery and the philosophical and psychiatric principles of existentialism. The ontological or intrinsic existential issues of death, isolation, freedom and meaninglessness are described and their manifestations are explored in clinical syndromes. When ultimate existential concerns are recognised, patients have an opportunity to understand their life on a deeper level that is not defined as a medical disorder but as a part of human existence. Understanding that existential concerns underlie a great deal of human behaviour helps to free patients from the stigma of psychiatric labels. An existential approach is a humanistic way toward recovery.*

**Key words:** *existentialism – death – isolation – freedom – meaninglessness – recovery*

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*“The soul in its essence will say to herself: no one can build the bridge on which you in particular will have to cross the river of life-no one but yourself. Of course there are countless paths and bridges and demigods ready to carry you over the river, but only at the price of your own self. In all the world, there is one specific way that no one but you can take...”*

*(Nietzsche from May, 1983)*

### INTRODUCTION

Existentialism is important in recovery because of the strong emphasis it places on the individual. In psychiatry clinicians should pay more attention to each individual's unique existential experiences. We found in our experience with existential group therapy, that existential principles resonate with the recovery model and help clinicians and patients/consumers transcend what they experience as the confining aspects of the medical model. (Goldner-Vukov et al. 2007)

The recovery model was adopted as a guiding principle in mental health in the United States in the 1980's. New Zealand (MHC 2001) and Australia followed and in 1998 New Zealand implemented the recovery model as a national standard of care (MHC 2001). The recovery model has similar origins to the 12 Step Recovery Model for Alcoholics Anonymous. Recovering alcoholics

found that traditional mental health approaches failed to meet their needs and lacked a basic understanding of what they were experiencing. The recovery movement expresses the desire of those receiving care to take ownership of their own path toward recovery. This parallels the philosophical and psychological ideas of existentialism. There are ongoing debates about the principles, terms and applications of the ideas surrounding recovery, but, in general, it attempts to develop a social model that moves away medical labels and empowers the individuals going through mental health experiences to regain control over their lives. Recovery can be seen as a journey of healing and transformation that enables a person with a mental health problem to live a meaningful life and achieve his/her full potential.

The essential elements of recovery revolve around the individual reclaiming and redefining their identity and defining the values important to their retaining ownership of their own lives.

Important values include hope, having a secure base and support system, self-empowerment, self-determination and inclusion in the process of engagement with the mental health system, as well as the development of wellness recovery action plans (WRAPS) (Copeland 1992, 1994, 1997). WRAPS are written by the patient/consumer in collaboration with mental health clinicians and they include a section in which patients/consumers describe how they would like to be treated in the event of a relapse, who should and should not be contacted, what medications are helpful and which medications have not been helpful and other advance directives for their care.

Patients/consumers who are not making clinical progress are often stuck in existential conflicts. Progress along the path toward recovery is not really possible without understanding and addressing existential concerns. We found that in existential group therapy for bipolar patients that it was when existential issues were addressed in the group process and patients confronted each other to take responsibility for their well-being and the effect their behavior had on others, that patients really accepted these challenges and changed their behavior (Goldner-Vukov et al. 2007).

Individuals with psychiatric conditions struggle with the same existential issues all human beings confront and yet, their experiences bring these issues to focus in unique ways. By understanding the underlying principles of existential thinking clinicians can assist patients in reclaiming a sense of ownership and meaning in their lives. It is vital for mental health professionals to recognize that patients have the freedom of choice about how to manage their lives and that it is only when they decide to assume responsibility for their life and their treatment that they will make any progress toward their recovery. Clinicians can assist patients/ consumers to establish a secure base. Housing New Zealand and the Ministry of Health both fund low cost housing for individuals and families. Work Income New Zealand provides financial benefits for individuals and families and in addition they have implemented a Workwise Program that places employment specialists in mental health centers to help patients/consumers find jobs. By offering assistance and support, skills training, socialization and occupational activities, clinicians can help patients/consumers deal with their feelings of isolation and regain confidence in their ability to

form friendships and belong and participate in life in meaningful ways. The restoration of hope is an area that deserves special attention.

## HOPE

When patients come to see clinicians they frequently do not ask the questions that are really on their mind nor do they talk about what really concerns them. It is unusual for a person to go directly to something close to their inner being without taking a variety of paths forward while at the same time they are asking themselves whether or not you, their clinician, is someone who will accept them, listen to them, be capable of understanding their concerns and have anything of value to offer them for the risk they take in making themselves known. This is an essential step in forming a collaborative relationship that supports the self-empowerment and self-determination important for recovery.

The archetype of a healer has been described as a universal phenomena in human beings (Campbell & Moyers 1991). When patients are able to trust their clinician, feel safe and respected, then the clinician/patient relationship allows the activation of the patient's internal healing belief system. This gives patients a sense of hope. Hope allows a relationship to develop in which the patient and clinician are able together to acknowledge and alleviate many of the deep issues of suffering that people encounter in life. Sometimes it is important to have a name for one's suffering. A cure is essential at times. Other times, it is important for one's suffering to be acknowledged and for one's courage to be recognised.

## Existentialism in Philosophy and Psychoanalysis

One of the most important values of existential philosophy is authenticity. Authenticity is above all a call to integrity, responsibility, and even to heroism. It asks an individual to be true to his/her inner self in the face of adversity no matter what the cost. (Solomon & Higgins 1996). In the early 1900's existential psychoanalysts began to emerge. After a few decades without much activity, Kierkegaard's work was translated into other languages and was taken up by the German Martin Heidegger who became an exponent of existentialism and the German psychiatrist Karl Jaspers who coined the term "Existenzphilosophie

(philosophy of existence)". Existential psychoanalysts, philosophers, writers and artists developed across Europe and spread to America as late as 1958 (May 1983).

Existentialism might be best conceived as a philosophical movement that includes philosophers, politicians, writers, artists, psychoanalysts, psychologists and psychiatrists. Irvin Yalom is a contemporary psychiatrist who has continued the work of existential psychiatry (Yalom 1980). Existential philosophers who emerged in the aftermath of the horrors of WWII stressed that it was individuals who gave meaning to their lives and not the world who gave them meaning.

### **Defining Characteristics of Existentialism**

The human existential dilemma is something fixed in the depths of the human character (Becker 1973). The existential nature of human existence is ontological, i.e., it is intrinsic to being human (Tillich 1952). Human beings are free to make decisions about life and are responsible for the outcome of these decisions. This creates an intrinsic anxiety or angst about the freedom to make choices (Yalom 1980).

The principles of existentialism can be summarized as follows: all human beings: 1) are centered in themselves, 2) strive to preserve and affirm their true being, 3) have a need for and the choice of extending themselves to others, an action that involves risk, 4) have the capacity for self-awareness, 5) have the capacity to know themselves as subjects who have a world and to know they are being threatened, and 6) have an ontological foundation for consciousness based on freedom (Tillich 1952).

### **Existential Phenomenology**

A phenomenon is that which appears and phenomenology is the study of appearances. Existential phenomenology is a way human beings have of understanding themselves and the world by means of careful descriptions of experience. The existential philosopher Edmund Husserl emphasized that experience could only be studied subjectively, that is, human life could only be viewed from the inside instead of pretending to view it objectively from the outside. A basic principle of phenomenology is the concept of intentionality, that all phenomena involve both an intending action and an intended object. In contrast

to the cognitive approaches already discussed, existential phenomenology focuses on understanding individual experience as an attempt to capture the essential meaning of existence. This philosophical current was inspired by Martin Heidegger who was influenced by the existential work of Kierkegaard who contended that existence was absolutely unique for each individual and the phenomenological work of Husserl (Stewart & Mickunas 1974, Luijpen & Koren 1969).

### **The Need for an Existential Approach**

The current approach to psychiatric problems is biopsychosocial, cultural and spiritual. We suggest an existential approach is needed to comprehend the wholeness of patients. Existential phenomenology supports the uniqueness of each individual and helps guide clinicians in establishing a respectful therapeutic relationship that is supportive of the recovery approach and the self-determination of patients. The existential approach presents the view that there are intrinsic conflicts that result from the awareness and confrontation of certain ultimate concerns that are an inescapable part of human existence. The major existential ultimate concerns are death, meaninglessness, isolation, and freedom. The fear of death, for example, is so overwhelming that human beings would not be able to function if this fear was totally conscious. The conflicts people experience and the defenses they develop around existential ultimate concerns are generally unconscious processes. They often become conscious through the manifestation of psychological symptoms, disorders or patterns of behavior. In a therapeutic relationship that recognizes existential issues, they are an important part of understanding the foundation and development of each unique individual person. In this paper, we have chosen to focus on the importance existential issues have in the therapeutic relationship and in assisting individuals to find hope and meaning that may allow a successful negotiation of recovery. Existential conflicts and defenses become an important part of the therapeutic process of making what is unconscious, conscious so individuals can achieve a greater sense of mastery and control of their lives. This is obviously a broad and ambitious agenda and a full discussion of this is beyond what this paper can address. In general, confrontation of

the intrinsic, i.e., ontological givens of existence can be painful and challenging but ultimately healing.

### **Psychopathology and Existentialism**

Psychiatric problems that are reflections of existential issues are frequently seen in primary care and psychiatry. They include: depression, anxiety, pain, somatization, substance abuse, and suicidality (Yalom 1980). An existential perspective is helpful in understanding many psychiatric symptoms and behaviors. Anxiety emanates from an individual's confrontation with the ultimate concerns of existence. The psychopathological manifestations are a graceless, inefficient, and ineffective defensive mode of coping with anxiety.

There are three types of existential anxiety (Tillich 1952). 1) The anxiety of fate or death in its pathological expression drives individuals to an unrealistic need for security. This anxiety is compounded to the degree that a person individuates. Unconscious pathological manifestations of the need for security include obsessive, compulsive and dependent behavior as well as the narcissistic preoccupation with acquiring power and wealth that underlies modern Western society. 2) The anxiety of emptiness and meaninglessness is created by doubt based on separation and isolation. In its pathological expression this anxiety drives individuals toward an unrealistic need for certainty or fanaticism. Problems with separation underlie the dynamics of all insecure attachment disorders. 3) Human beings experience an anxiety of guilt and condemnation. Its pathological expression this anxiety drives individuals toward an unrealistic need for perfection. The need for perfection can be observed in patients who are obsessed about side effects of medication and are trying to find a 'perfect' cure. People with eating disorders try to find a perfect body and the drive for perfection may be part of people's character structure (Tillich 1952).

When these three types of anxiety are not mastered and they are fulfilled or manifest in the state of despair which is a condition of no hope (Tillich 1952).

### **Existential Ultimate Concerns**

Conflicts arise as ultimate concerns intrinsic to human existence. Each individual faces the core

existential ultimate concerns in a highly individualized way: death, freedom, isolation and meaninglessness (Yalom 1980).

### **Death**

Death is the most obvious ultimate concern. The core conflict is between the awareness of the inevitability of death and the desire to continue living (Spinoza in Elwes, 2008). Human beings create defenses against the fear of death based on denial. These defenses shape the human character, influence the way individuals grow, falter, and fall ill. There are two modes of existence: one of forgetfulness of being ( a limited awareness of the true nature of existential ultimate concerns including death ) and one of mindfulness of being ( full awareness of the immences of death and ultimate existential concerns) which is described as authentic (Heidegger, 1996). The desire to transcend death is so ultimate and profound that it has been described as the source of all culture and creativity (Becker, 1973). Humans attempt to achieve immortality in the following ways: 1) biologically through procreation, 2) theologically through spiritual evolution, 3) creatively through work and art, 4) experientially through intense life dramas, adventures and experiences, and 5) by immersing oneself in the forces of nature (Lifton 1973b).

Rank believed a person was thrown back and forth in the process of individuation between the fear of life and the fear of death (Rank 1945). That is, between two poles of possibility: the affirmation of one's autonomy, emergence and potential that leaves one feeling unprotected and lonely and 2) the fear of loss of individuality by being dissolved back into the whole and becoming invisible (Rank 1945). People who individuate beyond conventional limits have an increased fear of death anxiety, an increased need for fusion and an increased need for a sense of belonging (Tillich 1952). People who suffer from mental illness are thrown into an unconventional life style, completely beyond their own choosing and this intensifies their fear of death and isolation.

### **Fear of Death**

Human beings are out of nature but hopelessly in it. Human beings are consciously aware of the true human condition but instead remain only partially conscious and play all sorts social games,

and use psychological tricks that keep them far away from the reality of death (Becker 1973). For example, people end up leading unbelievable lives when they are trapped in psychotic interpretations of reality, when they are absorbed in the madness of gambling and addictions and when they are completely preoccupied with forms of acting out and harming themselves and others in order to get revenge for their suffering. One way to cope with the fear of death is to pull back from the full potential of life. Mental illness provokes the fear of death and restricts an individual's potential for development (Maslow 1968). Every illness provokes the fear of death. Mental illness clearly increases the risk of suicide as an ultimate attempt to escape a perceived destiny or suffering.

People who do not succeed in taking upon themselves their existential anxieties, can escape the state of despair by developing neurotic symptoms. Neurosis is a way of avoiding the state of non-being by avoiding being (Tillich 1952). One of the manifestations of death anxiety is neurosis.

### **Manifestations of Death Anxiety**

Success neurosis is seen when people are striving to achieve success at any cost in order to 'prove' their immortality. Social phobia is the result of problems with individuation and the lack of development of social skills leading to social anxiety. Substance abuse is a means of achieving an altered state of consciousness as an escape from confronting the realities of existence. In order to avoid death anxiety people may develop a sense of specialness, a belief in personal omnipotence manifested by heroism, workaholism, narcissism, a refusal to accept necessary treatment, and rebellious behaviour in general. The belief in an ultimate rescuer is the need to be found, protected, and saved without asking for help. This is manifested by collapse when a fatal illness appears, depression when living in someone else's shadow, masochism, interpersonal difficulties and failing to separate from a relationship with aging parents (Yalom 1980). Psychiatric patients probably stop taking their medication and relapse as a result of a sense of specialness and a belief that nothing is wrong with them because they have an omnipotent power to heal themselves. In addition, when faced with dilemmas they can't resolve, they may regress to a state of believing in an ultimate rescuer and become helpless. Patients often give up or stop taking medication and hand

themselves over to fate as a way of refusing to face the challenges or destiny of their lives.

### **Freedom, Destiny and Responsibility**

Yalom assumes that freedom refers to the absence of an inherent design in life that leaves one responsible for all one's choices and actions. Freedom refers to the absence of external structure. The human being does not enter or leave a well structured universe that has an inherent design. Beneath human existence there is no ground, only a void, an abyss, nothing (Yalom 1980).

Freedom gives human beings the ability to modify destiny. Being responsible for life at the deepest level establishes a foundation for an individual's identity and existence. From the perspective of existential thinkers the individual is entirely responsible for creating his/her self, destiny, life predicaments, feelings, choices, suffering and actions (Yalom 1980). Individuals who reject responsibility for themselves, blame other people or phenomena for their life situations (May 1999).

It is not possible for human beings to be responsible for their genetic makeup, their family of origin, the state of the world around them or many other things. But human beings are responsible for what they make of their lives (Tillich 1952). Despair arises from being unwilling to be oneself (Kierkegaard 1954). Every falling away from ourselves is a crime against nature and leads to sickness (Maslow 1958).

The conflict in freedom is between the encounter with groundlessness and the desire for foundation and structure (Yalom 1980). Manifestations of this conflict include a variety of ways in which people can develop a psychic world where they do not experience a sense of freedom. Examples include a life dominated by compulsive fears or dominated by paranoia in which the individual's feelings and thoughts are attributed to others. The conflict around freedom and responsibility can also be acted out in the personality. For example, a hysterical personality may be a way of pretending to be an innocent victim, a borderline personality may be a way of acting out losing control, passive behavior may be a way of not asking for help or comfort and abusing alcohol and drugs may be an attempt to escape responsibility and to live in an alerted state of consciousness (Yalom 1980).

## Isolation

Isolation refers to human being's fundamental separation from others and from the world. The conflict is between absolute isolation and the desire for protection and belonging (Yalom 1980). Becoming an individual entails an eternal and insurmountable loneliness (Kaiser 1965). The major developmental task of existentialism is to resolve the conflict between fusion and isolation. Interpersonal and existential isolation are way stations for each other. Human beings separate to encounter aloneness but this allows them to return to relationships to engage more deeply with others (Yalom 1980).

Separation from the world, the experience of feeling lost and lonely, is the intrinsic state of the human condition that includes intrapsychic, interpersonal and existential isolation. Anxiety covers acceptance of the fact that human beings are born alone and die alone. Manifestations of the problem of isolation in Yalom's view include certain manifestations of narcissism including the Don Juan syndrome in which individuals are unable to make a commitment to one person and the behavior of disinhibited adolescents that may express the child's inability to tolerate the separation and loneliness of adulthood (Yalom 1980). People who have been traumatized may become trapped in their internal world of psychological and physical pain to protect themselves from further external trauma. Hypochondriasis may be seen as an expression of the fear of isolation where every physical pain reactivates the psychological pain of having been abandoned as an infant. As mentioned earlier, all psychological issues related to attachment disorders underlie the development of psychiatric disorders including anxiety, depression, substance use disorders and somatization. This reflects the essential understanding of existentialists that the negotiation of the conflict between fusion and isolation is the major developmental task of human beings.

## Meaninglessness

Meaninglessness is the human confrontation with an indifferent universe that compels individuals to construct their own meaning (Yalom 1980). One solution is to cultivate a transcendental relationship with what is divine (Buber 1965). Secular sources of meaning include altruism,

devotion to a cause, or self-actualization (Camus 1989, Sartre 1954). Meaning falls into three categories: 1) what one gives in creative work, 2) what one takes in terms of experiences and 3) one's stand toward suffering and fate (Frankl 1969).

Meaning refers to our sense of purpose. Meaninglessness is the chronic inability to believe in the truth, importance, usefulness or interest value of any of the things one is engaged in or can imagine doing (Maddi 1970). Lack of meaning perpetuates anxiety, isolation and despair. Manifestations of meaninglessness include: suicidality, alcohol or drug abuse, noogenic or existential neurosis, depression, low self-esteem, identity crisis, boredom, emptiness, apathy, cynicism, and lack of direction. As a result of being mentally unwell patients are frequently drawn into an intense conflict about their purpose in life. They are handicapped in their attempts to engage in creative work and to take a stand toward their suffering. They are hampered in finding meaning in their experiences by the social stigma of their illness and need intensive support to overcome the toxic experiences of rejection they suffer in their families and society.

## How to Assess Existential Issues in Psychiatry

When assessing patients, clinicians need to consider the presence of existential issues. It is necessary to recognise that the biopsychosocial, cultural and spiritual model does not sufficiently encompass the realities of human suffering. Clinicians need to consider existential issues in patients who are treatment resistant and suffer, for example, from anxiety, depression, somatization or pain, suicidality and addiction. It should be understood that there are layers of anxiety but that the deepest level of anxiety is related to one's personal understanding of ultimate concerns. Tillich (1952) states that underlying all anxiety is the fear that one will not be able to preserve oneself in the face of direct adversity. This describes the experience of people 'having a nervous breakdown', becoming overwhelmed by depression, anxiety, mania or psychosis. Ultimate concerns are universal and they are present in every individual in every culture. These can be approached by being present beside patients as they encounter bewildering and shattering experiences they cannot understand. In less overtly profound situations ultimate concerns can be

explored by listening to dreams and fantasies, observing behaviour, and asking open-ended questions about meaning. The goal of existential assessment is to help patients understand and remove or resolve obstacles to the crucial questions of being.

### **Existential Approaches and Interventions**

An existential approach is consistent with good psychiatric practice and emphasizes being empathetic and genuine. It suggests a willingness to grasp the meaning of patients' suffering. Existential assessment is focused on the dimensions of human existence in the here and now and discourages an emphasis on the past. Patients are encouraged to make authentic decisions, to discover truly responsible ways of dealing with life and the world and to think deeply about their life situation. It is important to promote the belief that patients can harness their anxiety and use it constructively. For example, it is productive for patients to see anxiety as an opportunity to change and to achieve their full potential. Clinicians can temper existential anxiety by encouraging people to reach out to others, to love and to participate actively in life (Tillich 1952).

After completing a comprehensive psychiatry history we recommend that existential concerns be included in the development of the psychiatric formulation. Individuals will have different encounters with ultimate concerns that play a role in their vulnerability to develop psychiatric disorders and shape the nature of their character and their defensive structure. There is not necessarily a 1:1 relationship between ultimate concerns and psychiatric symptoms or disorders as these conflicts may be experienced and expressed in very individualized ways.

We recommend that patients identify their most important life values and then rank their values from the most to the least important. Following this patients are asked to write down their life goals linking them to their values. This process highlights patients' major ultimate concerns and allows clinicians to help patients understand their ultimate concerns and see how they cope with their anxieties. This process allows for therapeutic interventions when patients means of coping are dysfunctional. For example, when a patient ranks health as the most important value, but does not attend to physical well-being at all

because of belief in being special. This person could benefit from gentle confrontation and perhaps shift to a more adaptive coping mechanism.

Group therapy is especially helpful to teach patients how their behavior is viewed by others, how it makes other people feel, how it creates the opinions others have of them and how it influences their opinions of themselves. In addition group therapy is especially helpful when peers confront each other about therapy-avoiding behaviors and behaviors that lead to the suffering of others due to failure to assume responsibility for one's actions (Goldner-Vukov et al. 2007).

Clinicians need to foster an understanding in patients that they participate in creating their own destiny. Clinicians need to understand the role patients play in their own dilemmas and find ways to communicate these insights. The goal is ultimately to support personal change by helping patients understand that the cause of their suffering is not always external, but may, in fact, be internal and related to deeply human ontological concerns.

### **Existential Themes That Point Toward Answers**

It is beyond the scope of this paper to address the existential approach to all psychiatric symptoms and disorders. Instead we have attempted to give a broad overview of how existential ultimate concerns may be involved in the development of psychiatric symptoms and disorders. We paid particular attention to how existential issues apply to an effective therapeutic relationship, and how they may be involved in treatment resistance/ nonadherence. In this section we will discuss themes that can help patients find hope and meaning in their lives. These suggestions involve atheist/ secular approaches such as that of Yalom, naturalistic/Taoist/ mystical approaches such as Alan Watts, the mythological approach of Joseph Campbell and theological approaches of religious beliefs suggested by Tillich, Buber, O'Donohue and Frankl.

By helping patients to be honest in facing the ultimate concerns that are causing or contributing to their psychiatric problems, patients can first of all begin to understand and know themselves more deeply. The more patients are able to know themselves and relate to their authentic true selves, the more they are able to participate in life (Tillich 1952). In supporting patients to affirm and preserve their own true inner beings, clinicians can

help them find their own inner source of power. In helping patients to develop the courage to be who they are, to love and participate in life they can begin to overcome their existential anxieties. The degree of virtue people can attain in life is determined by the degree to which they strive for and affirm their own being (Tillich 1952). This is not something that is beyond the grasp of people suffering from psychiatric disorders.

### **Responding to the fear of death and finding meaning**

Joseph Campbell, the eminent mythologist, says that myths are symbolic stories that reconcile human beings to the harsh realities of life (Campbell 1991). The first function of myths is to point to transcendence of consciousness and the unknown mystery of life. One universal myth across the world is that of the hero or heroine who is the personification of courage and strength and undertakes a transforming vision quest. The highest point of this quest is to confront death. The hero or heroine is challenged to follow the wisdom in their heart and not the contemporary conventional wisdom that will lead them to hell. The message of this myth is that the seat of the soul is inside and that it is in the soul that the inner and outer worlds meet. Each patient's life is their unique encounter with this myth and we need to acknowledge and validate the courage our patients require to follow the wisdom of their heart through their terrifying experiences.

Campbell admonishes that if clinicians want to help people in this world, they need to teach people how to live in it. He says that what human beings are seeking in life is all the experiences one can possibly have of being alive. Myths are clues to the spiritual potentialities of life. The spiritual and mythological fulfillment of life is that you are here, you exist, and you are alive (Campbell 1991).

Einstein reminds us that it was only to the individual that the soul is given. (Einstein) Not to the family, the church or society. It is only through the authentic and unique true self that human beings can discover the meaning of their lives.

### **Isolation and Belonging**

Psychiatric patients loose connection with their inner selves and with their environment. They become isolated. Psychiatric symptoms per se alienate patients from themselves and from others. For example, people who dissociate, who shift

back and forth between devaluation and idealization, between love and hate, loose connection with themselves and have difficulties establishing interpersonal relationships. The stigma of mental illness, being unable to work and living in poverty makes patients feel separated from their families and society. People who are isolated and disconnected often lack relationships that assist them in integrating their experiences. Without connections patients are subject to internal reality states that become a substitute for real connections with other people. In order to survive situations that are overwhelmingly traumatic, patients often develop a false self. When this false self speaks to patients, they experience it as external and foreign. When patients hear voices, for example, they are listening to some part of themselves that begs for understanding. When patients live in a false self they search for something that can never be obtained.

Longing and belonging are instincts of the soul (O'Donohue 1998). In interventions with patients clinicians need to help them belong first to their own soul and to see that real beauty is the light that comes from within them (O'Donohue 1998). It is the challenge of clinicians to help patients find the connections within themselves and to offer them a therapeutic relationship that will allow them to discover and develop new aspects of themselves.

One of the deepest longings of the soul is to be seen. There is no mirror in the world where one can glimpse the soul. The honesty and clarity of true friendship is the truest mirror. (O'Donohue, 1998) In therapeutic alliance with patients, it is the role of clinicians to provide patients with such a mirror. Clinicians need to help patients understand that what appears to be only negative also contains an opportunity for self-knowledge and self-mastery. By encouraging patients to adopt an attitude of hospitality and embrace that which is difficult and awkward clinicians can help patients to discover the positive meaning of their symptoms and to validate their suffering.

### **Acceptance, Faith and Freedom**

Whereas Western society has addressed some ultimate concerns in terms of secular or religious faith and beliefs, Eastern approaches have emphasized naturalistic ways of approaching life that don't involve conceptualizing a supreme being or entity. These include Taoism and Buddhism.



Acceptance is a basic and profound principle of eastern philosophical and spiritual beliefs. Radical acceptance has become one of the foundations of psychotherapy for complex emotional states in severe personality disorders, Bipolar Disorder, Schizophrenia and Schizoaffective Disorder. In addition to being oneself and finding meaning in life, acceptance allows people an additional layer of being that may contribute to finding happiness. In true acceptance of the self there is a mystery that something so apparently simple can contain so great a treasure. Is so happens that the very things human beings are forever struggling to get away from, to change and to escape are the very things that hold the much desired secret. For example, patients frequently want to destroy or get rid of part of themselves that is wounded when, in fact, the sad, angry, scared or helpless parts of them deserve compassion and understanding. One's present self and situation at this moment contain the whole secret (Watts 1940). Clinicians need to help patients accept the state of their own soul exactly as it is instead of trying to force themselves into some other state that they imagine to be superior. Faith is the willingness to give oneself to life absolutely and utterly without making conditions of any kind (Watts 1940). In doing this, one can begin to overcome existential dilemmas.

Human beings are always trying to interfere with their states of mind as they appear from moment to moment imagining that something else is better than what they experience (Watts 1940). Instead, clinicians need to encourage patients to allow the moment and all it contains freedom to be as it is, to come and go in its own time and in allowing the moment, which is what one is now, to set oneself free (Watts 1940). In doing this one can realize that life as it is expressed in the moment has always been setting you free from the very beginning but you have chosen to ignore it and tried to achieve something else. That is why total acceptance is actually the key to freedom (Watts 1940).

## CONCLUSIONS

Existential anxieties that emanate from the ultimate concerns of existence can interfere with the development, relationships, creative work and self-actualization of mental health patients. The anxiety of death and fate can lead to a preoccupation with security. By teaching patients to accept their true selves and find the courage to

love and participate in life, they may be able to overcome this anxiety and not be controlled by it. The anxiety of meaninglessness based on the fear of isolation may drive patients toward fanaticism. By establishing successful therapeutic relationships with patients, clinicians can help them feel a sense of belonging and move in and out of their fears toward relationships that allow them to integrate their traumatic and difficult internal experiences. The anxiety of guilt and condemnation is a result of the intrinsic state of freedom and it may drive patients toward perfectionism. If clinicians can teach patients to accept their lives and to give themselves to life absolutely and utterly without restraint, patients can find the key to their freedom and the path to recovery in this kind of total acceptance.

Changing perspectives and behaviours in a process that involves many conversations and dialogue amongst colleagues. We believe an existential approach to treatment has benefits and we invite future dialogue around this topic.

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