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Clara E. Hill

University of Maryland - College Park

Yoshi Kanazawa

Meigi Gakuin University - Tokyo, Japan

Sarah Knox

Marquette University, sarah.knox@marquette.edu

Iris Schauerman

University of Maryland - College Park

Darren Loureiro

University of Maryland - College Park

See next page for additional authors

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Authors

Clara E. Hill, Yoshi Kanazawa, Sarah Knox, Iris Schauerman, Darren Loureiro, Danielle James, Imani Carter, Shakeena King, Suad Razzak, Melanie Scarff, and Jasmine Moore

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Meaning in Life in Psychotherapy: The Perspective of Experienced Psychotherapists.

Clara E. Hill

Department of Psychology, University of Maryland, College Park, MD

Yoshi Kanazawa

Department of Psychology, Meigi Gakuin University, Tokyo, Japan

Sarah Knox

Department of Counseling and Educational Psychology, Marquette University, Milwaukee, WI

Iris Schauerman

Department of Psychology, University of Maryland, College Park, MD

Darren Loureiro

Department of Psychology, University of Maryland, College Park, MD

Danielle James

Department of Psychology, University of Maryland, College Park, MD

Imani Carter

Department of Psychology, University of Maryland, College Park, MD

Shakeena King

Department of Psychology, University of Maryland, College Park, MD

Suad Razzak

Department of Psychology, University of Maryland, College Park, MD

Melanie Scarff

Department of Psychology, University of Maryland, College Park, MD

Jasmine Moore

Department of Psychology, University of Maryland, College Park, MD

Abstract

Objective: Our goal was to explore the meaning experienced psychotherapists derive from providing psychotherapy, their beliefs about the role of meaning in life (MIL) in psychotherapy, how they worked with MIL with a client who explicitly presented concerns about MIL, and how they worked with a different client for whom MIL was a secondary and more implicit concern. **Method:** Thirteen experienced psychotherapists were interviewed and data were analyzed using consensual qualitative research. **Results:** Therapists derived self-oriented meaning (e.g., feeling gratified, fulfilled, connected) and other-oriented meaning (helping others, making the world a better place) from providing psychotherapy. They believed that MIL is fundamental and underlies all human concerns, including those brought to therapy. In contrast to the clients who had implicit MIL concerns, clients who explicitly presented MIL concerns were reported to have more interpersonal problems and physical problems, but about the same amount of psychological distress and loss/grief. Therapists used insight-oriented interventions, support, action-oriented interventions, and exploratory interventions to work with MIL with both types of clients, but used more exploratory interventions with implicit than explicit MIL clients. **Conclusions:** MIL is a salient topic for experienced, existentially oriented psychotherapists; they work with MIL extensively with some clients in psychotherapy. We recommend that therapists receive training to work with MIL in therapy, and that they pay attention to MIL concerns when they conduct psychotherapy. We also recommend additional research on MIL in psychotherapy.

Keywords

meaning in life, psychotherapy process, meaning therapists derive from doing psychotherapy, existential psychotherapy

People often search for meaning in life (MIL), which Yalom ([22]) defined as purpose and coherence, by asking questions such as "What am I doing here?" or "What do I live for?" Many theorists (e.g., Frankl, [3], [4]; Wong, [20]; Yalom, [22]) have claimed that meaning is essential for life and all humans strive for it. Frankl ([4]) further suggested that all humans require something to live for, and most want something for which they would be willing to die.

Given that concerns over MIL are inherent in the human condition, it is important to know more about it. Because of their training and practice working with clients about deep psychological concerns,

experienced psychotherapists are in a unique position to inform us about MIL. Of interest to us in the present study was learning about personal meanings therapists derive from doing therapy, their beliefs about the role of MIL in therapy, and how they work with clients who have MIL concerns.

Personal Meanings Derived from Working as a Psychologist/Psychotherapist

The role of the psychotherapist is demanding. Therapists must be able to conceptualize clients, have knowledge and skills to help clients, be aware of their own feelings and reactions so as not to hinder clients, be responsive to individual clients, and know when and how to refer and end with clients. Although research has been conducted on the motivations people have for becoming therapists (e.g., Farber, Manevich, Metzger, & Saypool, [2]; Hill, Lystrup et al., [9]), we found minimal research on the personal meanings therapists derive from doing psychotherapy.

In related research on psychologists, Kernes and Kinnier ([12]) found that counseling and clinical psychologists employed in academic and practice settings typically believed that the meaning of life is to love, help, and show compassion for others. Participants also noted that intimate relationships, family, and friendships brought personal meaning to their lives. In addition, when asked, "What matters most to you in your work as a psychologist?" the themes, in descending order of frequency, were: "Helping others to live more satisfying lives," "mentoring others," "being an agent of social change," "connecting to another person," "contributing something lasting to psychology," "self-growth and development," "conducting research," "having a good work atmosphere," "being competent," "recognition and praise," and "finding a balance between professional and personal life." Helping others and connecting were endorsed more often by the practitioners; whereas mentoring others, research, and contributing something lasting to psychology were endorsed more often by academic psychologists.

In a recent qualitative study, Hill et al. ([8]) found that 10 female doctoral-level counseling psychology students obtained both self-oriented meaning (feeling fulfilled and gratified, experiencing personal growth and insight, having a sense of connection and intimacy) and other-oriented meaning (helping others, making the world a better place) from providing psychotherapy. Such findings are indeed intriguing, but may reflect the views of a narrowly defined sample (i.e., female doctoral students from one counseling psychology program). Given their work with many clients and their age, experienced therapists may well report quite different thoughts about personal meanings derived from conducting psychotherapy.

Role of MIL in Psychotherapy

How important is it to work with MIL in psychotherapy? Is this really a concern that clients bring into therapy? According to some estimates by clinicians, approximately 20–33% of clients in psychotherapy explicitly report existential crises or concerns related to a lack of MIL (Frankl, [3], [4]; Jung, [11]; Yalom, [22]). For many others, MIL may be an implicit concern that underlies their struggles with substance abuse, obsessions, depression, delinquency, or risky behavior (Frankl, [3], [4]; Jung, [11]; Yalom, [22]). Although these estimates are imprecise and based on clinical judgment, they indicate that discussions about MIL may be quite salient for those seeking therapy.

More empirical data are needed, though, to provide more understanding of how experienced therapists think about the role of MIL in therapy. Is it a central concern? Is lack of MIL a sign of psychological distress? When is it appropriate to work with MIL in psychotherapy?

Interventions for Working with MIL in Psychotherapy

To the extent that MIL is fundamental to all clients, therapists from all theoretical approaches work with MIL. Most of the extant literature about interventions for working with MIL, however, comes from the logotherapy and existential traditions.

Frankl ([3], [4]) developed logotherapy, an approach devoted to making meaning. He specified four major techniques that therapists can use to help clients find meaning: (i) dereflection, where the therapist diverts the client's attention from self-absorption to searching for meaning outside of self, perhaps by developing empathy; (ii) paradoxical intention, where the therapist helps clients distance themselves from problems by suggesting that they do the opposite of what is worrying them, thereby breaking the cycle of symptom amplification (e.g., a person who is ruminating endlessly about not having meaning would be advised to get engaged in life); (iii) Socratic dialogue, which is used to guide the client into examining and discovering hopes and desires (e.g., a situation that the client considers meaningless is re-examined by asking questions and helping the client gain meaning); and (iv) discernment of meaning in past activities, such as creative accomplishments, experiences, and attitudes toward suffering.

Influenced primarily by Frankl, Wong ([21], [20]) developed meaning-centered therapy to help clients who present MIL concerns in psychotherapy. Wong's interventions seek to affirm that life has meaning through an approach that integrates theories; incorporates spirituality; has a relational, healing- and wellness-focus; is positive and hopeful; is multicultural in its orientation; emphasizes clients' narratives; and is psychoeducational. Wong's model consists of finding purpose, understanding situations, taking responsible actions, and evaluating satisfaction, all of which he accomplishes through such techniques as Socratic dialogue, dereflection, perspective-taking, and gratitude exercises.

In contrast to the directive, behavioral logotherapy approach, existential psychotherapy has provided a in-depth dynamic theoretical perspective to working with MIL (e.g., Hobbs, [10]; Maddi, [14]; Wolman, [19]; Yalom, [22]). For instance, Yalom suggested that therapists challenge clients' assumptions about meaning and help clients understand that they have to construct meaning rather than find "the" meaning. He also advocated that therapists be attuned to the importance of MIL and ask about clients' belief systems, love of another person, long-range hopes and goals, as well as creative interests and pursuits as ways to approach MIL. Furthermore, he recommended that therapists stay away from cosmic questions about meaning (e.g., is there some overall purpose?) and instead help clients find something that matters at the moment. He suggested that people cannot just search for meaning, but rather must be engaged in life to have a sense of meaning. He also suggested that the desire to engage in life is always present, and the therapist's task is to remove obstacles to such engagement by asking questions such as, "What prevents you from loving another person?" "Why is there so little job satisfaction?" "Why are you neglecting creativity or religion?" Finally, he suggested that the therapist's best tool is himself or herself. By relating deeply and authentically to client, therapists serve as models

to clients of personal commitment to engagement in life. Thus, therapists need to be aware of their own issues related to MIL in order to be fully engaged with helping clients.

These theoreticians/clinicians offer many ideas for what therapists can do in psychotherapy to help clients in their search for MIL. A commonality across the approaches is helping clients make sense of past experiences and constructing more meaning for the present and future. Another theme is the need to help clients become more actively engaged in life (to be less self-absorbed, to enter into activities, and to take responsible action).

Despite these several theories, however, we know little empirically about what experienced therapists actually do with clients who have MIL concerns. In the qualitative study mentioned above (the only study we know of), Hill et al. ([8]) asked 10 female doctoral-level counseling psychology students about how they worked with MIL in psychotherapy. The participants said that they rarely if ever directly worked with MIL in psychotherapy (e.g., asked about MIL or labeled problems as being related to MIL). Rather, they approached MIL indirectly by focusing on the components of MIL (e.g., purpose, goals). They also focused on other pressing topics in the hope that clients would gain meaning if these other more pressing concerns were resolved. This study provides useful information about how therapists-in-training work with MIL with their clients.

As noted above, a next logical step is to investigate experienced therapists, who not only typically have lived longer, but also have often invested substantial time and energy into learning about themselves and about psychotherapy. Studying experienced therapists may therefore yield additional insight regarding the role of MIL in psychotherapy and therapeutic interventions that can be used to help clients explore and construct MIL. Learning about how experienced therapists work with clients' MIL issues could also have implications for therapist training.

Recent Empirical Research on MIL

Much of the recent research on MIL has used the Meaning in Life Questionnaire (MLQ; Steger, Frazier, Oishi, & Kaler, [15]), a self-report measure with two subscales. MLQ-Presence (MLQ-P) measures the subjective sense of one's life as being meaningful and comprehensible, whereas MIL-Search (MLQ-S) assesses the degree to which one is engaged in a search for meaning. Steger et al. ([15]) suggested that presence and search are not necessarily related, given that people can have a strong sense of meaning and yet at the same time have either a great deal of, or little, interest in searching for purpose or MIL. Similarly, they could have a weak sense of purpose but be eager or not eager to search for purpose. Extensive research involving the MLQ has provided considerable knowledge about the importance of presence and search for MIL, in that MLQ-P has been associated with a higher sense of well-being, whereas MLQ-S has been associated with a lower sense of well-being. These findings need to be extended using qualitative approaches to learn more about how therapists think about and work with MIL in psychotherapy.

Using the MLQ, Hill et al. ([8]) found that doctoral students had higher presence but about the same amount of search as undergraduate students in psychology classes. Determining the levels of presence and search in experienced therapists would also be interesting to see whether there is some developmental trend.

Purposes of the Present Study

The first purpose of the present study was to assess personal meanings that experienced therapists derive from practicing psychotherapy. Second, we examined beliefs of experienced therapists related to the role of MIL in psychotherapy. Third, we investigated how experienced therapists work with MIL with clients. Given that Yalom ([22]) made a distinction between clients who explicitly address MIL versus clients who willingly address the issue if therapists raise it, and because doctoral student therapists in the Hill et al. ([8]) study only addressed MIL implicitly rather than explicitly, we specifically investigated interventions with two types of MIL cases: one in which clients presented MIL concerns very explicitly, and another when such concerns were raised more implicitly. For both explicit and implicit clients, we asked participants how MIL questions arose and developed over the course of their work with the client, and what strategies they used to facilitate the MIL work. Our final purpose was to compare our sample to previous samples on the MLQ.

Method

Design

The data for this study included interviews with 13 experienced therapists in independent practice in the United States (Hill, [5], recommended samples of 13–15 for CQR research). We analyzed the data using consensual qualitative research (CQR; Hill, [5]), which is ideal for obtaining in-depth descriptions of abstract, complex phenomena. CQR employs an open-ended interview format, which captures a broad range of participant responses, but still has ample structure to organize those responses. Because experiences and thoughts regarding MIL can be difficult to articulate, CQR's balance of structure and flexibility is a prudent method to study this topic. CQR has been used for a wide range of topics (see Hill, [5]). In particular, CQR was used in previous studies regarding MIL for undergraduate students (Hill, Bowers et al., [7]) and doctoral students (Hill et al., [8]), thereby enabling comparisons across studies.

Participants

Interviewees

Thirteen (7 male, 6 female; 11 counseling psychologists, 2 clinical psychologists) post-doctoral, experienced therapists, all of White European backgrounds, participated in the study. Mean age was 55.62 ($SD = 7.88$), and the mean number of years in practice was 26.19 ($SD = 11.05$). Using 5-point Likert scales (1 = not at all, 5 = very high) for their beliefs and adherence to theoretical orientations, they rated themselves as 4.00 ($SD = 1.15$) on humanistic/existential/experiential, 3.46 ($SD = 1.13$) on psychoanalytic/psychodynamic, 3.23 ($SD = 1.30$) on cognitive/behavioral, and 3.15 ($SD = 0.80$) on feminist/multicultural orientations. Thus, these therapists endorsed a humanistic/existential/experiential orientation more than other orientations.

Clients described by interviewees

Each therapist was asked to describe his or her work with one client who presented an explicit (overt) MIL issue, and a different client who presented an implicit (covert) MIL issue. Of the 13 clients who had explicit MIL concerns, there were 7 men and 6 women; of the 13 clients who had implicit/underlying MIL concerns, there were 9 women and 4 men. For age and years in therapy, we compared samples using effect size analyses (difference between means divided by the pooled standard deviations,

where > 0.20 is a small effect, and > 0.50 is a medium effect; Cohen, [1]). The explicit sample was slightly older than the implicit sample ($M = 55.15$, $SD = 9.22$ vs. $M = 52.08$, $SD = 17.36$ years, $d = 0.22$), and had been in therapy for less time ($M = 2.97$, $SD = 2.84$, one missing information, vs. $M = 4.73$, $SD = 5.92$ years, three missing information, $d = 0.38$).

Research team

Eight (seven female, one male; two White European American, two African American, two mixed race/ethnicity, two Hispanic American; age $M = 21.75$, $SD = 2.96$) senior undergraduate psychology students comprised the primary research team. They were voluntarily enrolled in a class on CQR at a mid-Atlantic US public university. The first author presented the idea of studying MIL prior to enrollment, and all students agreed to take part.

Three (two female, one male; two White European American, one Asian) experienced psychologists served as interviewers and auditors, and two of these same people served as co-instructors of the class. Their mean age was 59.00 ($SD = 6.56$), and their theoretical orientations as assessed on the 5-point scales were: humanistic/existential/experiential ($M = 3.33$, $SD = 1.15$); psychoanalytic/psychodynamic ($M = 3.33$, $SD = 0.58$); cognitive-behavioral ($M = 2.67$, $SD = 1.15$); and feminist/multicultural ($M = 2.67$, $SD = 0.58$).

Biases/Expectations of Research Team

After reading the chapter on biases/expectations in Hill ([5]), students wrote papers and discussed this topic extensively in class; senior members of the research team wrote brief summaries of their thoughts. We briefly report these biases/expectations here to give context for the members of the research team. Of the eight students on the primary research team, seven reported that MIL was very important to them personally, in that they thought about it a lot, especially during times of crisis and transition. The eighth person did not think about MIL a lot and did not consider it a major personal concern. In terms of psychotherapy, all thought that although MIL is not typically a presenting problem, it may be an underlying feature of all problems, and it is important for therapists to address MIL with some clients. Five people indicated believing that MIL and symptoms were equally important foci of psychotherapy, whereas three thought that MIL was a more important focus than symptoms. For the three interviewers/auditors, all had spent considerable time reflecting on MIL for themselves and believed that MIL is an important topic for psychotherapy, although not always the direct focus. All members of the research team were encouraged to reflect on their biases/expectations and then set them aside (i.e., bracket them) as much as possible during data analyses.

Measures

Meaning in Life Questionnaire

(MLQ; Steger et al., [15]) is a 10-item, face-valid, self-report measure assessing a person's MIL. Factor analyses were used to develop two subscales: Presence of Meaning (MLQ-P; e.g., "I have discovered a satisfying life purpose") and Search for Meaning (MLQ-S, e.g., "I am seeking a purpose or mission in life"). Items are rated on a 7-point scale from 1 (*absolutely untrue*) to 7 (*absolutely true*). Steger et al. reported positive correlations between MLQ-P and measures of well-being, as well as positive correlations between MLQ-S and measures of negative affect, depression, and neuroticism, supporting

the validity of the scales. They also reported adequate internal consistency (.84 and .81, respectively) and 1-month test–retest reliability coefficients (.73 and .70, respectively) for the MLQ-P and MLQ-S.

Demographic form

Questions were asked about age, sex, race/ethnicity, highest degree, specialty area of psychology (i.e., counseling, clinical), and number of years seeing clients. Participants also rated themselves on the four theoretical orientations mentioned above.

Interview protocol

The first three authors developed the initial interview protocol using the Hill et al. ([8]) protocol as a starting point. They consulted extensively (via email correspondence) with two psychologists in private practice to make sure the questions reflected the experiences of practitioners. In the final protocol, interviewees were first told that we defined MIL as purpose, goals, sense of coherence, intention, aim, or function. They were then asked questions about personal meanings derived from conducting psychotherapy and general thoughts about working with MIL in psychotherapy. They were then asked to select one client who came in specifically seeking help for MIL and for whom the therapist felt that MIL was a central and explicit concern (explicit client). For that explicit client, they were asked a series of questions: background/history/demographics, the MIL issue, how the discussion about MIL started, how the discussion about MIL deepened, why they chose particular strategies for working with MIL, how the client responded to their approach, challenges they encountered working with MIL with this client, and what they wish they had done differently in working with this client related to MIL. They were then asked the same series of questions about an implicit event, where a different client came in seeking help for something else, but whose concerns seemed to be related to MIL. Finally, they were asked about additional thoughts about MIL and about their experience of the interview. The interview was semi-structured, such that there was a standard set of questions, but interviewers were encouraged to use probes (e.g., "Tell me more about that," "What do you mean by that?") to elicit further individualized responses.

Procedures

Ethical considerations

The University Institutional Review Board approved the study. Participants all signed consent forms prior to participation in the study. Before data analysis, participants were assigned code numbers to protect confidentiality.

Recruiting interviewees

Because the general guideline in CQR is to select a sample of participants who have experience with the topic, we studied experienced therapists who had worked with MIL in psychotherapy so that we could acquire a good foundation for how experienced therapists work with MIL. We did not restrict our sample to any particular theoretical approach because we conceptualized MIL as a pantheoretical topic, one that applies to all clients and all theoretical perspectives.

The first three authors used personal contacts to invite colleagues from around the United States to participate using the following criteria: The participant had to be a PhD-level counseling or clinical psychologist in private practice, had to work with MIL in her/his psychotherapy practice, and had to be open and eager to talking about their work with MIL. Initially, we asked that therapists focus on

successful cases of clients aged 50+ whom they were currently seeing or with whom they had mutually terminated within the past 6 months, and with whom they had worked for more than eight sessions. We used these criteria because we wanted a homogeneous sample of clients, and we thought the 50+ sample would be more likely to have salient MIL concerns about such things as retirement, physical health, and death. We also asked participants to choose one client who presented an explicit MIL problem, and one client who sought help for something else but for whom MIL was an underlying concern. After a few therapists indicated that they could not participate because they did not have appropriate clients, we eliminated the criteria related to client age and number of sessions.

In the email invitation, prospective participants were sent information explaining the study, a consent form, the MLQ, the interview protocol (so that they could determine if they had eligible clients and could then prepare to talk about those clients in the interview), and a demographic form. They were asked to sign the consent form, complete the MLQ and demographic form, and return all forms to the first author prior to the interview. Of the 23 people who were sent an invitation via email, 13 agreed and participated, 7 did not participate because of not having eligible clients or not having time, and 3 did not respond to the invitation (no follow-up requests were sent).

Data collection

Each interviewer conducted an audio-recorded, 60- to 120-minute, telephone interview with four or five participants. Interviews were transcribed by primary team members, noting nonverbal behaviors such as pauses and laughter, but excluding minimal verbal behaviors (e.g., "um," "mm-hmm"). Transcribers removed any identifying information from the transcript, and recordings of interviews were erased after they had been transcribed. Transcripts were identified using code numbers.

Preparation for data analyses

Undergraduate student team members read about CQR and MIL, completed the MLQ, and discussed CQR and MIL with the co-instructors.

Data analyses

The first author drafted an initial list of domains (i.e., topics discussed during the interviews), which the entire team (eight team members and the co-instructors) modified by reading several transcripts out loud until a stable list emerged. The entire team then consensually assigned all content from two transcripts into one or more domains. Once team members understood the process, pairs of judges consensually assigned transcript content to one or more domains, with the co-instructors monitoring their work.

Table I. Means and standard deviations for MLQ-Presence, MLQ-Search for Steger et al.'s (2008) samples of American and Japanese young adults, campus norms, 10 interviewees from Hill, Bowers et al. (2013), 10 interviewees from Hill et al. (2014), and 13 interviewees from current study.

	MLQ-P		MLQ-S	
Steger et al. (2008), N = 1183	24.1	6.7	24.5	6.6
Campus norms, N = 2799	24.8	6.5	24.5	8.2
Hill, Bowers et al. (2013) undergraduates, N = 10	23.6	4.9	26.0	6.8
Hill et al. (2014) doctoral students, N = 10	28.6	2.6	24.6	9.4
Current sample experienced therapists, N = 13	30.1	2.8	20.1	8.4

Note. Steger et al. ([16]) samples were of young adults. Campus norms come from census data gathered in 2011 of 2799 entering first-year students (Raque-Bogdan & Lucas, personal communication, March 7, 2012). High scores on the MLQ-P indicate high levels of the presence of MIL; high scores on MLQ-S indicate high levels of search for MIL.

The research team and co-instructors then constructed, with considerable discussion, core ideas (i.e., summaries or abstracts in fewer and more concise terms) from the domain data for two interviews/cases. Pairs of judges then constructed core ideas for the remaining cases, with monitoring by the co-instructors. Each finalized consensus version (core ideas within domains for an individual case) was audited for accuracy by one of the co-instructors and the external auditor, and then revised after careful consideration and discussion by the team members responsible for that case.

For the cross-analysis, the first author or a team member presented initial ideas for categories (themes) for each domain (i.e., based on the core ideas for all cases in the domain), and then the research team worked together to refine the categories and subcategories through reading the core ideas for each domain. The categories and subcategories were substantially revised through lively debates as the entire team worked together to place each core idea into one or more categories/subcategories.

The external auditor then reviewed the cross-analysis for each domain, and at least two team members consensually made the necessary revisions. Finally, each team member returned to the raw data for her/his interview and made sure that all of the raw data were accurately captured in the cross-analyses. The co-instructors and external auditor then again reviewed the findings and made final revisions until all were satisfied that the final cross-analyses adequately represented the data.

Throughout the process, co-instructors were careful not to impose their biases and expectations but instead encouraged student team members to arrive at their own conclusions through open discussion and debate. Co-instructors provided feedback, but emphasized that there are many ways to approach data. All perspectives were considered equally valid, and differences in opinion were resolved through consensus reached through discussion.

Finally, a draft of the manuscript was sent to all interviewees so that they could confirm that their anonymity was adequately maintained, and so that they could comment on the results. Eleven of the 13 participants responded; three minor suggestions for changes were incorporated into the manuscript. All responding participants indicated that confidentiality for themselves and their clients had been maintained.

Results

Table I shows the means and standard deviations of scores on the MLQ-S and MLQ-P for young adults in Steger, Kawabata, Shimai, and Otake ([16]), first-year undergraduate students on the same campus as the current study, undergraduate students in Hill, Bowers et al. ([7]), doctoral students in Hill et al. ([8]), and the current interviewees. The current sample was higher (effect sizes were medium to large, ranging from 0.55 to 1.81) than all other samples on MLQ-P, but similar to all other samples on MLQ-S (effect sizes ranged from 0.03 to 0.23).

In this section, we report the data from the interviews (see also Table II). For each domain, we provide quotes from the interviews using a code number related to the interviewer to protect the confidentiality of the participants. Ellipses (...) are shown when interview data were deleted for efficiency and clarity in presenting the findings. Similarly, we deleted phrases such as "like," "you know," and "I mean" for ease of reading. For each domain, *general* refers to results that applied to 12 or 13 participants, *typical* for 7–11 participants, and *variant* for 2–6 participants. Importantly, these numbers reflect the number of participants who provided data that fit within each category rather than the number who might have endorsed the category had they been cued with various possibilities (as is done in survey research).

Table II. Categories and subcategories within domains for personal meaning derived from providing psychotherapy and theoretical and clinical musings about meaning in life.

Domain/Category/Subcategories	Total sample	Explicit client		Implicit client
Personal meaning derived from being a psychotherapist				
Self-oriented meaning				
Enjoys and feels fulfilled	G (12)			
Allow personal, intellectual, emotional growth	T (10)			
Allows for connection and intimacy	T (9)			
Other-oriented meaning				
Help others or alleviate suffering	T (11)			
Make a better world	T (7)			
Role of MIL in life and psychotherapy				
MIL is the essence of humanity	T (8)			
MIL underlies all client problems	T (8)			
MIL is positive/lack of MIL is negative	T (7)			
Only work with MIL under certain conditions				
Other client problems not more pressing	T (8)			
Crisis	T (7)			
Client is open/motivated to work on MIL	V (4)			
Description of Client				
Presenting problems				
Current psychological distress		T (11)		G (13)
Current interpersonal concerns		T (11)	^a	T (7)
Physical health concerns		T (9)	^a	V (3)
Loss/grief due to death of significant others		V (6)		V (5)
Client characteristics				
Open/motivated		G (13)		G (12)
Resistant/defensive		T (10)		T (11)
MIL issues				
Nothing to live for/lack of purpose		T (10)		T (10)
Relationship issues		V (5)		T (8)
Identity issues		T (8)	^a	V (4)
Initiation of MIL in sessions				

Client initiated		T (9)	^a	V (4)
MIL emerged through extensive therapist probing and client exploration		V (4)	^a	T (9)
Therapist interventions for working with MIL clients				
Insight-oriented		G (12)		T (10)
Support		T (10)		T (11)
Action-oriented		T (9)		T (11)
Exploratory		V (6)	^a	T (10)
Therapists' personal reactions to MIL clients		V (6)		V (6)
Experience of interview				
Promoted reflectivity	G (13)			
Positive reactions	G (12)			
Challenging/difficulty articulating	T (11)			
Nervous about impression on interviewer	V (3)			
Wants to see results	V (3)			

Note. N = 13. G = General (12–13 participants), T = Typical (7–11 participants), V = Variant (2–6). ^aSubsamples differed by at least 30% (four cases).

Personal Sources of MIL from Being a Psychotherapist

Participants spoke at length about what they gained from being therapists. It was clearly not just a job, but rather an endeavor that gave them a great deal of personal meaning. They described deriving both self-oriented and other-oriented meanings from their work as therapists.

Self-oriented meaning

Generally, participants reported that they enjoyed providing psychotherapy because they felt rewarded, gratified, satisfied, and fulfilled by their work. For example, S3 said, "Selfishly, I do therapy because it's good for me ... it brings out the best in me." For Y3,

There are activities that I do in my life that I can't find impact or meaning, but when I do a session of psychotherapy, I never have to question whether or not that's meaningful or whether or not that activity inherently has meaning. It's just really important to me.

Participants also typically stated that providing psychotherapy gave them a space in which to develop themselves personally, emotionally, and intellectually. C3 said,

It's also really intellectually satisfying ... to try and be a creative thinker or to collaborate with clients and encourage them to think outside the box, devise innovative solutions for their problems ... When I'm with a client, I'm engaged intellectually and emotionally. I'm never bored, or very, very rarely bored, and even that is interesting to me.

Being close to clients and sharing a bond in therapy was also a typical self-oriented meaning, given that being a therapist allows for connection, intimacy, and closeness. Y1 highlighted this interconnectedness, stating, "The whole experience of doing psychotherapy with people, for me, has fundamental meaning to it, because it involves being humanly connected to another person in fundamentally important and significant ways."

Other-oriented meaning

Typically, participants derived meaning from helping others and alleviating the pain of individual clients. For C1,

[It gives me meaning] if I can help alleviate their suffering in some way, help them see their lives differently or from a different perspective, help them have more love and compassion for themselves, and see themselves as more than their struggles.

Typically, participants also gained meaning through psychotherapy by helping make their corner of the world a better place, and then having that spread out systemically to other parts of the world (a ripple effect). As stated by Y3,

Sometimes I think about this room full of people that maybe I had a positive impact on ... because of the time that we spent together ... maybe they make an impact on somebody else and that just kind of goes on like a ripple effect ... the same way that trauma affects one person and then it affects the next person and their family and it affects people across generations, maybe psychotherapy could affect a person, could affect a family, could affect bigger systems.

Role of MIL in Life and Psychotherapy

Therapists typically believed that seeking and finding MIL is the essence of humanity, and a fundamental aspect of human nature, the reason for being. For C4, "the nature of being alive and human is to struggle with thinking about meaning, especially when faced with death."

Relatedly, participants typically believed that MIL underlies all client problems and therefore must be addressed in psychotherapy. For Y4, "MIL is pervasive and global and needs to be a part of the healing process, even if not dealt with explicitly. Helping clients address how they derive meaning is an important aspect of psychotherapy."

Furthermore, participants typically viewed having MIL as a positive quality and a lack of MIL as a sign of psychological distress. For example, Y4 described "MIL as a sense of purpose, understanding and acceptance of self, recognition of one's own strengths and limitations, and accepting one's own life challenges and strengths they can bring to this world."

Participants had specific recommendations about when it was appropriate and inappropriate to work with MIL in psychotherapy. They typically said that they would not work with MIL if other client problems were more pressing and needed to be addressed immediately, although they might work with MIL once these other issues had been resolved. S1 said, "I never really think about meaning in life as a primary issue, to me it's always a secondary issue ... to me depression is primary and issues of meaning in life are secondary."

In apparent contradiction to the previous recommendation, participants also typically said that during times of crisis (such as when the client is suffering from relationship issues, trauma/loss, depression, or suicidal ideation/attempts), it is crucial to work with MIL. Y5, for example, said,

For example, a traumatic life event in the world that may come up ... It certainly came up around 9/11. What is our place in the world? Are we doing the right things? Do we have a right around how we treat people? Do we have a right to expect others to treat us in certain ways? And what gives us that right?

Variantly, participants stressed that clients need to be open and motivated for MIL work. For C1, "I don't know that all clients would be open to that [talking about MIL]. I think you have to have some sort of existential, spiritual, kind of zen that finding meaning, you're looking for meaning in life."

Working with Clients Who Have Explicit vs. Implicit MIL Concerns

Case examples

In this section we first present case examples to illustrate how therapists worked on MIL with explicit and implicit clients, and then we compare the qualitative results for the two samples. Names that appear below are pseudonyms.

Client with explicit MIL concerns

Susan (C3) was in her 60s, married, with no children. As a result of two heart attacks, Susan lost her career as a nurse, her community, her identity, her good health, and her income; she was on a full disability. Both of her parents had died recently, and Susan was frustrated that, as a nurse, she was not able to help them more. Another loss was that after her parents died, her family was no longer close. Susan presented with extreme anxiety and agoraphobia. She had lost her direction and purpose in life because of the losses. She felt aimless, had no energy and enthusiasm, and did not feel like herself.

Dr Z believed that Susan needed to understand why she was living before she could effectively learn skills to cope with her anxiety. They examined Susan's religious beliefs and discovered she no longer had any connection to her religion. They also examined her strong work ethic and discovered that the only source of her MIL was her work. Dr Z used questions, clarification, reflection, curiosity, and enthusiasm to help Susan explore MIL. Because Susan was smart and enjoyed a good challenge, Dr Z was able to be gently confrontational, and could also joke, teach, and use more paradoxical interventions with Susan than with other clients. Dr Z suggested that Susan could create meaning for herself and that this meaning could change over time. Dr Z also shared different examples of ways that people find MIL. Susan was surprised to learn of ways to find MIL other than helping others and making a difference in people's lives.

As a result of working on MIL in therapy, Susan discovered that she could actively work to *create* a new MIL and that she could continue to find purpose in her life by helping others in a different way from nursing. She reconnected with her family, assuming a support role for her nieces and nephews by sending notes of encouragement, money, and gifts, and giving advice. She also saw herself as a patient advocate for members of her extended family, for example, by visiting a rehabilitation center to assess the care her sister was receiving. In addition, she volunteered to speak at her nursing school. Although Susan still struggled with agoraphobia, identifying goals gave her motivation to work to overcome her anxiety in crowds and being away from home. She viewed herself as passing on the values and legacy of her much admired parents.

Client with implicit MIL concerns

Jane (C4), a woman in her 70s, and her lesbian partner began couples therapy because they were arguing and were unhappy with each other. Jane was angry because she was working full time and

maintaining the household, whereas her partner was not doing anything. Dr P wondered why Jane was always doing everything and asked what would happen if Jane let her partner do some of the tasks. Jane started crying when she realized that she would feel empty if she let her partner do the household chores.

At this point, Dr P suggested that a shift from couples therapy to individual therapy with Jane. Dr P was then able to help Jane become aware that she did things for others because otherwise her life felt empty. As they explored, Jane cried a lot, and Dr P helped her stay with her sadness. Jane also talked about growing older and not seeing herself as competent and capable. In addition, she feared being dependent on others. Jane felt very vulnerable and frequently wondered who was going to take care of her. Much of therapy consisted of allowing space for Jane to ask these questions and experience the feelings related to them.

Jane responded well to therapy. She felt understood, and seemed to consider it a safe place. She began making more connections with her daughter and grandchildren, and doing more pleasurable things for herself. At times she reverted to a care-taking role with her son, but then she remembered what she and Dr P had discussed.

Comparison of explicit and implicit samples

To compare the two client samples (explicit vs. implicit presentation of MIL) using the qualitative data, we used the guideline suggested by Ladany, Thompson, and Hill ([13]) that subsamples had to differ by at least 30% to be considered a meaningful difference (e.g., 8 of 13 therapists, 62%, would be considered different from 3 of 13 therapists, 23%). Note that we did not rely on differences between frequency categories (e.g., typical vs. variant) to determine meaningful differences because typical and variant can sometimes vary by only one case (e.g., seven vs. six in this study), which does not seem meaningful; likewise, requiring differences of at least two frequency levels (e.g., general vs. variant) is often too stringent given that general rarely occurs (Ladany et al., [13]). "Meaningful differences," to which we refer below, then, met the 30% threshold.

Client presenting problems

At least typically, both explicit and implicit clients had current psychological distress (e.g., anxiety, depression, trauma, substance abuse, and personality disorders). Both types also typically had current interpersonal concerns (e.g., divorce, family fights, lack of connection), although explicit MIL clients manifested more of these concerns than did implicit clients (a meaningful difference). In addition, explicit MIL clients typically had physical health problems (e.g., disabilities, heart problems, cancer), whereas implicit clients only variably had these problems (a meaningful difference). Finally, both explicit and implicit clients variably had suffered from loss/grief due to the death of significant others. Thus, clients with explicit MIL concerns, as compared to implicit MIL clients, were more often characterized as having interpersonal concerns and physical health problems.

Client characteristics

Both explicit and implicit MIL clients were generally described as being open and motivated. Therapists used terms such as likeable, friendly, and intelligent to describe these clients. They were all actively engaged in the work of therapy related to MIL, in that they explored, searched for insight, and made

changes. They often brought questions to facilitate their therapy sessions, and explored on their own outside of therapy. Of the explicit client, C1 said,

One of the first things I did, maybe in the first session, was I referred her to [a] self-compassion book. It seemed like a natural fit to start out by helping her feel more compassionate to herself, which, again, she took it, she read it, realized very quickly what she was doing and right away was able to turn and be more compassionate with herself.

For S3's implicit client,

She brings up these questions about whether she's got a right to take up oxygen given how much suffering she's experienced, whether life is worth living, she just gravitates quite naturally toward them. It's just who she is. It's quite natural for her. She's a fairly deep thinker and quite bright. So yeah, I'm typically following her lead on the existential issues.

In addition, and in seeming contrast, both explicit and implicit clients were also typically resistant, defensive, unable to process emotion, and unmotivated. About the explicit client, C2 said,

This guy, when he first sat down to talk to me, he appeared, he looked to me like somebody who might as well have said 'I don't think you can help me, but my doctor thinks I should be here.'

With the implicit client, S1 had to be cautious because the client

has a tendency to be submissive and wants to please. You have to be careful because that comes from a submissiveness and a desire to please me. I really have to be careful about not interpreting receptiveness as not just him trying to garner my approval and agreeing with me.

MIL issues

A typical MIL issue for both types of clients involved feeling that they had nothing to live for, a lack of purpose, or a search for meaning (e.g., "What is my meaning?" "What do I have to live for?"). S3's implicit client was

suicidal with some frequency and wonders if life is worth living. She had this major [heart problem] ... She very nearly died and the recovery process was long and very difficult for her. It called into question repeatedly whether it was worth it or if she should just give up.

Relationship issues (e.g., getting meaning from relationships) were variant for explicit clients and typical for implicit clients (not a meaningful difference). Relationship issues involved such things as the absence of a connection (e.g., death of a loved one, divorce, loss of affection) prompting questions about MIL and why clients were feeling this way, as well as a search for something to ease the pain they felt. An example is Y4's explicit client:

She described feeling distant in her relationship with others or not being sure of what relationships mean for her in a deeper way because of the estrangement from her father and having to be a caretaker for her father at the end of his life. Other aspects, her distance with her biological son and her mother, seemed to have not been very nurturing ... and her marriage not working out ... she has a number of these relationship losses ... just some dysfunction

where she felt that she was not sure where she's ... how to connect or what it means to truly feel connected.

Identity issues (e.g., "Who am I?") were typical for explicit clients and variant for implicit clients (a meaningful difference). Clients were often forced to think about their identity when suffering through a life-changing experience such as the loss of a loved one, overwhelming feelings of depression, or upcoming retirement. The MIL issue for S2's explicit client was,

She felt just that everything was gone ... she had lost her house, she lost her husband, she had stopped working, and so she really felt that she had nothing, no money ... She'd had some traumatic experiences being a social worker, hearing about some horrible things ... I think she had some PTSD ... a bit of the crisis ... I think that was part of the meaning in life is "How do I, Where do I go from here? How do I put life back together" ... some of it was identity and also like where, who is she, where is she going.

Initiation of MIL in sessions

The discussion of MIL was typically initiated by clients in the explicit cases but only variably in the implicit cases (a meaningful difference). The initiation by clients, however, was only variably direct and straightforward (e.g., S3's explicit client started therapy wanting to do a life review), whereas in other cases the clients variably talked tangentially about meaning issues (e.g., lack of purpose, not having a fulfilling job) but agreed that they were struggling with MIL when the therapists labeled it as such.

In contrast, the discussion of MIL was typically the result of extensive therapist probing and client exploration in the implicit cases compared to being only variant in the explicit cases (a meaningful difference). These therapists indicated that getting to MIL was very gradual and required probing and exploration.

Therapist interventions for working with explicit and implicit MIL clients

Participants described four types of interventions used to facilitate MIL with these clients (presented in the order of frequency of occurrence): insight-oriented, supportive, action-oriented, and exploratory.

Insight-oriented interventions. Therapists generally with explicit clients and typically with implicit clients (not a meaningful difference) used insight-oriented interventions to facilitate understanding of the role of MIL in life, self, or relationships. About the explicit client, Y3 said:

We also looked at childhood patterns and how some of his childhood patterns were manifesting in his relationship with his wife and her controlling him or him going along with things and not putting up a fuss, not really thinking about what he needed or wanted. So focus on interpersonal relationships, focus on the past, and trying to help him understand himself.

About the implicit client, Y5 said,

I named them [her issues] as looking for meaning, looking to be able to live consistent with what is important to her with her values. I felt it helped her with understanding what it is that she is struggling with, what it is that creates challenges for her. We were able then to talk about some of the things that she was, that were important to her, the things that she was struggling with in a way that was more directly and clearly about some of the issues of meaning in life.

Supportive interventions. Therapists typically used support to encourage clients and instill hope. They were empathic and compassionate, tried to build the therapeutic relationship, and were responsive to clients' needs. For C4's explicit client, "The early work was just allowing her to truly acknowledge and experience that frightened, lonely, despairing part of her, and the compassionate presence of myself, nonjudgmental, I think that was really important work for a long time." For the implicit client, C3 said, "I really liked her and I really empathized with her ... I looked forward to working with her."

Action-oriented interventions. Therapists typically encouraged clients to make changes or suggested new directions to help clients improve their lives and thereby gain more meaning. For S4's explicit client, "She had grandkids through one of her adopted kids, and I thought very much about ways she could connect with them and be a loving presence in their life." For the implicit client, C3 helped the client explore options, shifting the focus to engaging with her family instead of her involvement with the church, "You seem close to your family, are there ways you can put in your time at work and really shift the priority to engaging with your family."

Exploratory interventions. Therapists typically helped implicit MIL clients and variantly helped explicit clients explore MIL, values, and goals (a meaningful difference). More specifically, they facilitated exploration of MIL issues through skills such as reflection of feelings, restatement, and open questions. For S4's explicit client,

My reflections to her would often lean in the direction of an invitation to talk about value or the meaning of whatever experience she was having, and by following her energy in that I would lean into particular relationships that she was talking about.

For S3's implicit client, "I used pretty basic exploration type interventions to explore whether life to her is worth living, and did values exploration, which she does find meaningful, what has kept her going in the past."

Therapist personal reactions

Therapists variantly mentioned being hindered in their MIL work by countertransference feelings, feeling incompetent, or a lack of expertise or training. For the explicit client, C2 said it was "real countertransference. I looked at this guy and he was just the opposite of me. He fires questions without regard of my feelings and my first thought is, 'Am I sensitive to his feelings?'" Y1, in talking about the implicit client who had committed suicide, felt

overwhelming guilt or remorse that I hadn't done something right. There weren't many clues there that I had. But it's hard to know because it happened so quickly and unexpectedly ... My reading of things was that we had these things pretty well managed ... and I only discovered subsequently that we weren't.

Reactions to the Interview Experience

Participants generally had positive reactions to the interview, saying that the interviews were rewarding, interesting, and meaningful. In addition, they stated that the interviews promoted reflectivity about clients, themselves, or MIL. C3 said,

The whole process has been really thought provoking ... It's really a good opportunity for me to try to more clearly formulate what I think of meaning in life. I value the pursuit for myself and for my clients. I don't think I've had the chance to ever try to think it through.

Participants also typically stated that they had difficulty articulating their thoughts given the abstractness and complexity of the topic. S3 said that it was, "difficult sometimes to put words to really personal events or constructs, and I wonder if the words are really capturing what I'm intending to convey."

Discussion

Based on their many years of practice, these experienced therapists had accumulated considerable wisdom about MIL, valued MIL, and focused on it in psychotherapy with at least some of their clients. They had thought deeply about what they gained from doing therapy, about the role of MIL in life and psychotherapy, and about how to help clients in their search for MIL.

The participants scored higher than previous samples of undergraduate and doctoral students in terms of MIL-Presence. These results suggest that participants had a well-developed sense of purpose in life, which makes sense given that they were very committed to the practice of psychotherapy and had engaged in self-reflection, personal therapy, and supervision. Interestingly, they were about the same as other samples in terms of MIL-Search, suggesting that they were not currently searching for meaning any more than the other samples. It seems healthy that they would continue reflecting about meaning, but not necessarily searching for meaning.

Personal Meaning from Conducting Psychotherapy

These experienced psychotherapists gained both self- and other-oriented meaning from conducting psychotherapy. As such, it was not only important to provide psychotherapy to help others and make the world a better place, but these therapists provided psychotherapy because it made them feel good and gave meaning to their own lives. They felt alive, fulfilled, and gratified when working with clients, and they thrived on the intimacy and connection inherent in doing so. They also felt gratified by sharing in the lives of clients and helping them overcome difficulties.

With one exception, the results in terms of self- and other-oriented meanings from providing psychotherapy replicate the findings of Hill et al. ([8]) for doctoral student therapists. The exception is that doctoral students also variably stated that providing psychotherapy fulfilled a talent. Perhaps fulfilling a talent was more salient to younger therapists who were just discovering or confirming their talents. The similarity of results across the two studies suggests that the type of meaning derived from helping does not change over time. Experienced therapists seemed more able to attain meaning, however, because they were less anxious, more skilled, and more able to help clients.

The Role of MIL in Life and Psychotherapy

These therapists, who tended to be humanistically/existentially oriented, strongly believed that all people struggle with concerns about MIL. Not surprisingly, then, they believed that concerns about meaning, such as feeling a lack of purpose or direction, explicitly or implicitly infused all client problems. They also theorized that having MIL is positive and not having it is associated with pathology; specifically, lack of meaning often underlies depression. Not having a satisfying career, for

instance, causes many to lack a sense of meaning and purpose or a chance to leave a legacy. Likewise, for people who find meaning in relationships and caring for others, the loss of a significant other can be devastating. Hence, these therapists strongly agreed with Frankl ([3], [4]), Yalom ([22]), and Wong ([21], [20]) that MIL is one of the fundamental existential concerns that must be addressed in life, and in therapy, whereas an absence of MIL leaves many clients feeling uneasy and lacking direction or identity.

Although they believed that MIL undergirded all client problems, therapists clearly stated that it is not appropriate to focus on MIL with all clients. They acknowledged that other problems might be more pressing and need to be addressed first, even if doing so means that MIL is never directly discussed in therapy. That said, they also strongly indicated that MIL needs to be addressed in some crisis situations. More specifically, when clients experience trauma, loss, depression, or manifest suicidal ideation or gestures, they indicated that it can be appropriate to examine underlying questions about purpose, goals, and meaning. Such traumatic situations often force clients (and all of us) to think about MIL. When one's world is turned upside down, one has to reconsider beliefs about a just world and one's place in the world. As with the Chinese saying that a crisis presents an opportunity, the client (often with the therapist's support) has the opportunity to reevaluate and change directions to find meaning amid difficult experiences.

The therapists also noted, however, that clients need to be open to and motivated for MIL work. Some clients are introspective and love thinking about existential issues, but others just want more immediate relief and do not want to think about such concerns. Therapists must thus attend to client readiness for such work in discerning its place, if any, in the therapy.

Working with MIL in Psychotherapy

Types of clients who present with MIL concerns

According to these therapists, both explicit and implicit MIL clients typically had considerable psychological distress, thus paralleling the general client populations, and also echoing Steger and Shin's ([17]) review that a high level of search for meaning is related to psychological distress. Interestingly, those with explicit MIL issues more often reported interpersonal and physical health concerns than did the implicit MIL samples, suggesting that interpersonal problems and physical health concerns may be triggers for thinking about MIL. Another clue is that clients who presented implicit rather than explicit MIL concerns were younger, and thus may not have had as much opportunity to think about existential issues. The implicit, compared to the explicit, clients had also been in therapy longer, suggesting that they had other concerns that they needed to discuss prior to talking about MIL.

Thus, the picture emerges of those who explicitly present with MIL issues as having experienced severe life circumstances (e.g., physical illness) that forced them to confront their mortality and think overtly about MIL. It may have been easier to address MIL with such explicit clients because they were faced with crises that demanded a focus on meaning.

In retrospect, we suspect that the distinction among clients who present with MIL concerns explicitly, implicitly, and not at all is blurry, and that in fact the explicitness of MIL concerns falls on a continuum. It may be that awareness of MIL is something that changes over time and can be fostered, much like

Stiles ([18]) description of problematic experiences moving in successful psychotherapy from being ward off to being explored and mastered.

We should note that all of the clients were described as open and motivated for treatment, although they were also frequently described as having resistances and defenses. These findings reflect the ambivalence that clients often feel about changing, especially with difficult existential problem. Furthermore, we were struck by how much detail the therapists shared when describing their clients: We suspect that these clients may have been more engaging and memorable than other clients for these therapists, perhaps because of their MIL issues.

Initiation of MIL in sessions

According to the participants, only a few of the clients, even those with explicit MIL concerns, directly stated at the beginning of psychotherapy that they wanted to work on MIL (e.g., one client wanted to do a life review). More often, clients talked about related concerns (e.g., feeling despondent about losing a job and having health concerns) and readily agreed with the therapists' interpretation that these were MIL concerns. For some clients, however, MIL issues emerged only after therapists did extensive probing and exploration with the clients. Relatedly, previous estimates indicated that only about 20–33% of psychotherapy clients present with MIL concerns, although MIL may be related to many other presenting problems (Frankl, [3], [4]; Jung, [11]; Yalom, [22]).

Therapist interventions used to work with MIL

Therapists most often used insight-oriented interventions in their MIL work with clients to help clients gain understanding into the meaning in their lives, themselves, and their relationships. Meaning involved acquiring a new understanding of past situations or finding new meaning (goals) for the future. Similarly, Frankl ([3], [4]), Yalom ([22]), and Wong ([21], [20]) discussed helping clients search for, question, challenge assumptions about, find, and reconceptualize meaning.

The second most frequent intervention used by these therapists was support. Therapists actively encouraged clients and instilled hope that clients could develop meaning. They were empathic and compassionate, helping to validate clients' pain and suffering rather than denying it. They were attentive to the therapeutic relationship and responsive to client needs and abilities. In short, they cared about their clients deeply. Undoubtedly, becoming vulnerable and approaching a deep, abstract, difficult, and potentially scary topic such as MIL requires a safe relationship with a therapist who understands how unsettling it is to think about such existential issues. Interestingly, Frankl ([3], [4]), Yalom ([22]), and Wong ([21], [20]) did not specifically highlight the need for support when working with MIL. Perhaps they assumed the foundation of support and thus did not specifically articulate the need for it.

The third most frequently used interventions involved actively encouraging clients to make changes in their lives and suggesting ways to enact such changes. Thus, therapists were not just insight-oriented and supportive; they were also directive and behavioral in their approach to working with clients. As suggested by Hill ([6]), they seemed to believe that clients needed to act on their insights in order to improve their functioning (although it was not clear whether insight preceded action, as Hill suggested). Such use of action-oriented interventions is similar to Yalom's ([22]) suggestion that clients

need to be encouraged to engage in life, and that meaning would flow from such engagement. Wong ([21], [20]) also focused on the need for clients to take responsible action.

Finally, therapists engaged in exploratory interventions, such as facilitating clients in telling their narratives related to meaning, asking clients about their goals and values, and inviting clients to experience their feelings about meaning. Interestingly, therapists used more of these exploratory interventions with their implicit than explicit MIL clients. Given that these implicit MIL clients had fewer interpersonal concerns, fewer physical health concerns, fewer identity issues, were younger, and had been in therapy longer, therapists may have had to work harder to help these clients recognize that MIL concerns might underlie other concerns. Similarly, Yalom ([22]) noted the need for exploratory interventions such as being attuned to meaning issues and asking about clients' belief systems and obstacles to finding meaning. Neither Frankl ([3], [4]) nor Wong ([21], [20]) mentioned the use of exploratory interventions.

In contrast, a number of interventions suggested by Frankl ([3], [4]), Yalom ([22]), and Wong ([21], [20]) were not mentioned as being used by therapists in the current sample. For instance, our participants did not specifically indicate using dereflection, paradoxical intention, or Socratic dialogue, as Frankl ([3], [4]) recommended, nor the structured psychoeducational approach advocated by Wong ([21], [20]). Furthermore, they did not report challenging assumptions about meaning, nor asking about belief systems or creative pursuits, as Yalom ([22]) suggested. These differences are perhaps not surprising given that none of our therapists specifically indicated that they aligned themselves theoretically with Frankl, Yalom, or Wong, although a few mentioned that they had read Yalom's work. It could also be that they did not mention these interventions spontaneously, but might have indicated using them if they were given a list of interventions such as is done in survey research.

A comparison to the interventions suggested by the doctoral student therapists in the Hill et al. ([8]) study is also informative. The doctoral student therapists used only one intervention for working with MIL, which was to ask clients about goals and motivations. Otherwise, they focused on other clinical problems, assuming that resolution of these problems would enhance MIL. Thus, they were less likely to directly pursue MIL in psychotherapy, perhaps because they feared approaching such a delicate topic and were unsure about how to work with MIL. Although they had thought about MIL for themselves, the doctoral student therapists may not have been prepared for tackling these deep existential issues in therapy because of their lack of life and clinical experience, and their lack of training related to MIL. The experienced therapists, on the other hand, seemed to feel more comfortable approaching MIL, perhaps because they had learned over time to be more direct about talking about MIL.

Therapist personal reactions to working with MIL clients

About half of the therapists reported having personal reactions to working with MIL with these clients. They noted countertransference, feelings of inadequacy, or a lack of training to work with MIL problems. It is not surprising that addressing clients' existential concerns raised anxiety within therapists, for doing so may well have tapped into their own existential questions.

Summary

There was no distinct set of interventions that these therapists used to work with MIL as compared with other presenting concerns. Indeed, support, exploration, insight, and action skills are typically recommended across integrative therapies (e.g., Hill, [6]), Rather, an awareness of MIL seemed to provide these therapists with a lens or perspective through which they viewed client problems and then intervened accordingly.

Experience of the Interview

As with the undergraduate students (Hill, Bowers et al., [7]) and doctoral students (Hill et al., [8]) in previous MIL studies, participants in the current study enjoyed the interview, yet also noted difficulty in articulating their thinking about MIL. Clearly, it is challenging to talk about such an abstract, complex, existential topic, but participants were nevertheless eager to do so.

Limitations

These results should be considered in the context that these experienced therapists in independent practice were White European American, humanistically/existentially oriented, believed in the value of working with MIL in psychotherapy, and were personally invited to participate because of the likelihood that they might believe in and work with MIL in psychotherapy. We do not know whether these therapists were effective at treating clients with MIL issues, just that they worked on MIL with at least some of their clients. In addition, we do not know any more about specific training they received in humanistic theory or logotherapy.

Another limitation is the difficulty that therapists noted in terms of articulating their thoughts about MIL. Participants in the other two qualitative studies about MIL (Hill, Bowers et al., [7]; Hill et al., [8]) similarly mentioned difficulties articulating their thoughts. We believe that this problem is related to the abstractness of the construct of MIL. Hence, although participants in all three studies were very engaged in the interviews and said that they thought the topic was very important, they struggled to clarify their thinking and communicate with the interviewers.

In terms of limitations related to clients, we note that we changed the criteria after some potential participants did not have appropriate clients (successful cases of clients aged 50+ with whom they had worked for more than eight sessions). As a result, our sample was more mixed in terms of client age, number of sessions of therapy, and perhaps presenting problems than might have been desired. We would suspect that client MIL issues would differ across the lifespan (e.g., younger clients would think more about launching a career and forming romantic relationships, whereas older clients would think more about retirement and finding something else meaningful in life, and perhaps suffering the loss of significant others). In addition, the clients chosen by the therapists may have been more memorable than the typical population of therapy clients, so the results might generalize only to similar clients.

Implications

Given that clients rarely begin psychotherapy by labeling their concerns as MIL-related, the primary implication for practice is that therapists should be attuned to MIL issues in their clients, especially when clients are facing crises of some sort and appear to suffer from a lack of meaning. Therapists can be supportive and listen; ask about meaning, goals, and values; actively help clients make meaning out

of past experiences and find meaning in suffering; and actively encourage clients to engage in meaningful activities (e.g., engagement with family or friends, religious/spiritual activities).

Therapists should also be mindful of difficulties in addressing MIL issues in therapy. Clients may be open and collaborative, yet occasionally also resistant and defensive, perhaps because of the inherent difficulty in confronting existential concerns. Given such contradictory responses in clients, therapists should monitor their own reactions to ensure that they do not interfere with the therapeutic process.

Furthermore, therapists might want to examine their own MIL concerns, as well as anxieties they have about working with clients' MIL issues, given that such anxieties might interfere with the therapeutic process. Training regarding working with MIL concerns in therapy would also be helpful. In addition, therapists need to have a wide repertoire of therapeutic interventions, from exploration to action-oriented techniques, to work effectively on MIL issues.

With regard to research implications, we encourage others to investigate MIL in psychotherapy from other perspectives and using other methods. For example, a qualitative study of client experiences of addressing MIL in therapy would be interesting. In addition, the results of this study could be replicated using a survey method with a larger sample of therapists from different theoretical orientations working with a variety of clients; such a study would allow us to answer the question of how often MIL is a focus of the work in psychotherapy. Studying moments in psychotherapy during which MIL is discussed could also be revealing, as would examining changes in MIL across the course of psychotherapy or client age. It would also be interesting to investigate the degree to which therapists' awareness of and resolution of their own MIL concerns relates to their ability to work with clients' MIL issues. Finally, we need to know more about how to introduce MIL with clients, especially those who do not explicitly present with MIL issues, but for whom MIL may indeed be relevant.

Footnotes

Authors 4 through 11 are listed in a random order because they contributed equally.

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