

Miss B Pursues Death and Miss P Life in the Light of V. E. Frankl's Existential Analysis/Logotherapy

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Abstract

Ms B's in United Kingdom and Ms P's in Finland choices in life when dealing with acute ventilator-assisted tetraplegia were analyzed by means of Viktor E. Frankl's existential analysis/logotherapy. The freedom of will to existential meaning and to worth in one's suffering realizes in the attitudinal change the person chooses or is forced to adopt when subject to severe circumstances. Life becomes existentially meaningful relative to inescapable suffering by the completion of three values: creative, experiential, and attitudinal values. If the search for meaning on these paths is frustrated or obstructed, a person's will to meaning transforms into existential frustration along with an existential vacuum and feelings of despair emerge and harm the person's will to survive. However, a person's frustrated meaning in life, when subject to unavoidable severe conditions, can be averted and redirected by applying the basic tenets in an existential analytic/logotherapeutic approach to the extreme situation.

Keywords

existential analysis/logotherapy, existential meaning, V.E. Frankl, tetraplegia, ventilator assistance

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Introduction

Existential Analysis/Logotherapy

In this paper, existential analysis refers to the philosophical and scientific basis of logotherapy (gr. *logos* meaning), which constitutes an applied therapy based on the psychological-anthropological model developed by Viktor E. Frankl (1905–1997) (Viktor Frankl Institute, 2010). By existential analysis/logotherapy, the attitudes of Ms B in United Kingdom and Ms P in Finland toward their permanent predicament, their choice to either pursue death or life when dealing with acute ventilator assistance and paralysis from the neck down, are scrutinized. European existentialism has been found to have implications for both psychology and psychotherapy (Maddi, 2004), although its frequent theme has been “meaninglessness” implying that our lives lack an ultimate purpose. An existential futility is the fundamental permanent condition-of-being, no matter what we change, the meaninglessness continues and pervades every dimension of our lives. Nothing we do will make life ultimately meaningful (Park, 2004). Nonetheless, Kierkegaard (1813–1855) claimed that the human being can potentially create his or her own subjective “meaning” or “purpose” in life, and each individual is therefore the only one responsible for giving meaning to his/her life (Kierkegaard, 1978, 2011). But our search for meaning in life, the walk on a path toward an unfamiliar future, provokes ontological anxiety and put our existential courage to test (Maddi, 2004).

Frankl was the first existentialist who emphasized positive existential givens for his theory even though he himself was deported to four Nazi camps (KZ) in 1942–1945, including Auschwitz, where Josef Mengele directed him toward the gas chamber. Against all odds, Frankl managed to slip into the line of persons who were left to live and was transported to the KZ camps. During his incarceration, Frankl was confronted with many questions about his own meaning of life, which later led to his development of existential analysis. Frankl (1984) put forward that what really matters in what seems to be a context of inescapable suffering is a change of attitude that we courageously choose and need to adopt. The therapeutic value of Frankl’s existential analysis lies in the disclosure of an individual’s concrete existential situation and the preparation for giving assistance in the person’s autonomous search for meaning (Batthyany, 2013). This thinking is in line with Jaspers (1883–1969) philosophy; he used the words “limit situations” for those circumstances that define our humanity and where we face guilt, death, pain, suffering, and failure. Limit situations force us to confront ourselves in a disturbing way and make us true to ourselves and our lives. Therefore, we should assist people to come to terms with inescapable conflicts and problems of living parallel to asking themselves how they can proceed in another and perhaps more desirable direction (Jaspers, 1971).

Will to Meaning

Frankl (1984, 1992, 1997) sees in each circumstance of life both universal meaning and individual meaning. Even in situations characterized by seemingly lack of freedom such as being subject to paralysis with ventilator assistance, we *always possess an inner freedom of choosing our response to the situation*. “The one thing you can’t take away from me is the way I choose to respond to what you do to me. The last of one’s freedoms is to choose one’s attitude in any given circumstance.” The human being is a whole that includes body, mind, and spirit. The physical body may become ill, but the spiritual core (noëtic *nucleus*: *gr. noös* mind or spirit, *nucleus* la. core) remains healthy, given that the path to the noëtic core stays unblocked and therefore does not compromise the existential meaning. Noö dynamics refers to the tension between what people already have achieved and what they still ought to accomplish, “zwischen sein und seinsollen” [between “to be” and “to become”]. The noölogical dimension is the sphere of human consciousness, the locus of freedom and responsibility (Hatt, 1965) because we are responsible for our freedom to make choices, to say yes or no to the possibilities life is constantly offering us simultaneously with urging us to fulfil existential meaning, that is, to complete our best alternative or achievement, experience of and attitude to any given situation (Frankl, 1961, 2009a, 2009b). Therefore, we must act in a responsible manner with full understanding of our actions (Frankl, 1992).

Frankl (1961, 1992) refers in accordance with Jaspers (1971) to pain, guilt, and death but names this inevitable suffering the “tragic triad.” The tragic triad instigates the development of the “tragic optimism,” that is, a person’s ability to make the best out of an unchangeable overwhelming situation. Life’s negative aspects can be turned into something positive: by revolving [inescapable] suffering into an achievement; by deriving from guilt the opportunity to transform oneself for the better; and by drawing from life’s transitory nature an incentive to take meaningful action. Thus, a person is challenged in the face of guilt to improve and in the face of death to act in a responsible manner and with full awareness of the action (Frankl, 1992). Furthermore, humans are capable of resisting and braving terrible conditions through *self-transcendence* by detaching themselves, at least momentarily, from the situation. For example, the use of humor is a sign of a detached self (Frankl, 2009a; 2009b). In accepting inevitable suffering, life retains meaning even in extreme conditions to its very last moment.

Frustrated Will to Meaning

The restorative effect of the successful search for meaning is evident (Fabry, 1996; Kyung-Ah et al., 2009). However, a person’s will to meaning can become frustrated. The frustrated will to meaning leads to existential frustration that can result in *noögenic neuroses*. Frankl observed that people with noögenic neuroses in

the experience of purposelessness responded with behaviors that were *harmful to themselves, others, and society* (Frankl, 1984). The term “existential frustration” refers to the phenomenon of a misdirected search for meaning (e.g., when it is harmful for the person); it can occur from prolonged periods of boredom and apathy (Zaiser, 2005). Frankl (1984) stresses that feelings of life’s meaninglessness lead over time to despair and Despair equals Suffering minus Meaning ($D=S-M$): Despair is also loss of hope in reaction to a collapse in the defining characteristic of one’s self or one’s identity; it is not just an emotion, it is the loss of self, a state when one has the wrong conception of oneself (Existentialism, 2013). Despair may lead to suicide. An “existential vacuum” is at hand when one’s life is depleted of meaning, and this gives way to demoralization with the core thought “Life is of no value,” that is, no life is of value, in contrast to depression with the core thought “I am of no value” (Boeree, 2006). So far, Frankl’s (1984) existential analysis/logotherapy stresses the “will to meaning” as a motivational force in the human being. However, meaning can also be found in unavoidable suffering: first, by doing a deed or creating a work, second, by experiencing something inspiring or someone to love, and third, by identifying value in inescapable suffering by adopting an attitude or change of attitude to the specific circumstance (Batthyany, 2013). “When we are no longer able to change a situation, we are challenged to change ourselves” (Frankl, 2012).

Meaning in Extreme Conditions

Frankl (1947/1975) took as a point of departure for his theory Nietzsche’s: “Wer ein Warum zum Leben hat, erträgt fast jedes Wie.” [He who has a “why” to live for can bear with almost any how]. Frankl claimed that the “will to meaning” is a motivational human force judged against Sigmund Freud’s “will to pleasure” and Alfred Adler’s “will to power” (Wong, 2006). Frankl’s positive existential givens are made up of four components; a belief in a person’s healthy spiritual core, helping the person to become aware of the resources of his/her healthy core, assisting him/her to use these resources, and finally to grasp that life does not owe us happiness, it offers us meaning (Viktor Frankl Institute, 2010). Furthermore, Frankl (1984) arrived at the conclusion that even a life in severe circumstances had a chance to become existentially meaningful. This happens through the walk along three pathways: by completing creative values, by experiential values or the occurrence of something inspiring or love, and by attitudinal values which means that we choose or are forced to change our attitude toward unavoidable suffering. Self-transcendence facilitates the attitudinal change. To assist the client to discover their existential meaning the method of Socratic dialogue which equals modification of attitudes is useful. Certain attitudes and expectations constitute obstacles to meaning fulfillment. They can alienate a person from his meaning potentialities, thus accentuating or producing neurotic disorders via repeated maldecisions and formations of

behavior patterns. However, the person who assists the individual's in his/her search for meaning must abstain from imposing own values or meaning perceptions on the patients/clients; namely, people are guided to be aware of their own unrealistic and counterproductive attitudes in order to build up a new view that constitutes a better basis for a fulfilled life even in extreme circumstances (Frankl, 1988). This "spiritual midwifery" lifts up into awareness the option to find, and the freedom to fulfill, meaning in one's life (Batthyany, 2013). This is why Frankl's existential analysis/logotherapy was considered appropriate in the present paper, for examining inescapable suffering in extreme conditions.

Aim

In this paper, we meet two women: Ms B in United Kingdom and Ms P in Finland and discover their individual ways of dealing with the questions posed by life in a Franklian sense, when subject to inescapable suffering. Both Ms B and Ms P required acute ventilator assistance as they were paralyzed from the neck down. In 2001, Ms B struggled to show that she had the mental capacity to have the right to make her own decisions, even grave ones, about her future medical treatment. The case was not about the patient's best interests but about her mental capacity to make her own decision about future treatment. This did not necessarily mean that Ms B would choose death, but her choice was to have assistance to discontinue artificial life support (EWHC 429, 2002). In 2002, Ms B was assisted to discontinue artificial life support, a decision that predictably ended her body's ability to continue functioning as an integrated whole.

In contrast, Ms P was one of 3,115 persons who were afflicted with polio between the years 1950 and 1959, and subsequently in 1960 about 100 persons suffering from hypo-respiration were ventilated already in one of the hospitals in Helsinki. Ms P witnessed deaths of her room mates in the university hospital room, and she had no desire to die. She went down, in her opinion, an existentially meaningful route of adjustment to unforeseen events. In 2001, she planned to open an exhibition of her mouth-painted porcelain pieces and in 2002 she opened it. If both ladies are considered mentally competent, if both have the same religious view on the sanctity of life, and if both are subject to the same extreme condition, what makes Ms B pursue death and what makes Ms P pursue an existentially meaningful future out of the same predicament? The aim of the present paper is to offer a plausible suggestion relative to this question and to analyze the active choices these two women made in the light of Viktor Frankl's existential analysis/logotherapy.

Method

Viktor E. Frankl's (1947/1975) existential analytic/logotherapeutic approach in examining Ms B's and Ms P's choices to discard life and live life, respectively,

is at hand. Both ladies were women of faith. Both Ms B and Ms P required acute ventilator assistance as they were paralyzed from the neck down and for both women the year 2002 became a turning point in their lives. This twist of fate ignited a thought of writing this paper as one of the authors visited Ms P's exhibition while the press acknowledged what happened to Ms B. Therefore, an existential analytic/logotherapeutic approach is applied to enhance the understanding of what happened based on the documented court protocol concerning Ms B request to be judged to have the mental capacity to choose to refuse further treatment (EWHC 429, 2002); it can be read that this judgment is being handed down in public on March 22, 2002. It consists of 31 pages signed and dated by the judge together with the injunction, consisting of two pages, granted in respect of publicity (EWHC 429, 2002). The documented court protocol was weighed against a personal interview with Ms P, to which she would not have agreed, if not the first author would have known one of her hospital room mates, who died at the age of 16 years during the autumn 1962. The first author became acquainted with Ms P during the summer 1962 when the author came from abroad to work as a young help-nurse during a 2-month period in the ward for ventilator-assisted patients with paralytic poliomyelitis at the University Hospital of Helsinki, Finland. In Finland, from 1950 to 1959, 3,115 persons attracted polio, and a great deal of care focus was laid on the type of ventilator. Routine immunization with inactivated polio vaccine was initiated in Finland in 1957 (MMWR, 1986). In 2006, patients were still alive from the outbreaks in the 1950s and 1960s, and four patients have still to rely on the ventilator assistance (MMWR, 1986). However, Ms P gave her informed consent in written to participate in the present interview, which took place in October 16, 2012 for 5 hr in her home, situated some hours away from the capital. The interview was a semi-structured, in-depth interview at a date of Ms P's choice. No paid attendant was present in the room, and notes were completed during the interview and corrected, when repeated over phone, for hours at several occasions from October 17 to December 5, 2012. Open-ended questions and probes such as "can you tell me about the time for the tracheotomy?" were given. The present method can be described as Peirce's model of abduction. Peirce abduction had its accurate place in the context of discovery, the stage of inquiry in which we aim to generate theories that may then afterward be assessed. As he says, "abduction is the procedure of forming explanatory hypotheses. It is the only logical operation which introduces any new idea" (CP 5.172); in another place, he says that abduction encompasses "all the operations by which theories and conceptions are engendered" (CP 5.590). Details about Ms B and Ms P are provided in Tables 1 and 2. Their comments are given in Table 3.

Table 1. Factors Impacting Miss B's Life.

Date	Minus factors	Plus factors
1958–1966	Unhappy childhood; Moved to United Kingdom; Unmarried	Degree in Social Science and Social Work; Master of Public Policy and Administration; Practice teacher for Social work; Management Diploma from London College; Team manager of social workers; Head of department and principal officer for training and staff development; Ms B had a close circle of friends and a dear godchild
1999, August	Hemorrhage of the spinal column in the neck	
1999, September	Ms B was informed of a small risk of rehemorrhage, or surgical intervention resulting in disability. She executed a Living Will stating that treatment was to be withdrawn if she was suffering from a life-threatening condition, permanent mental impairment, or permanent unconsciousness.	Ms B recovered and returned to work.
2001, January	General weakness and numbness	
2001, February Hospital ICU	13th to intensive care unit (ICU); intramedullary cervical spine cavernoma; complete paralysis from the neck down; 16th respiratory problems and put in ventilator. 24th she tells about her Living Will	The clinicians were not prepared to turn off the ventilator.
2001, March Hospital	Neurological surgery with bitter disappointment and request to switch off the ventilator	Ms B regained ability to move her head and to articulate words

(continued)

Table 1. (continued)

Date	Minus factors	Plus factors
2001, April	Ms B mental capacity was assessed by two psychiatrists, and they amended their reports to state that she had not capacity. She was relieved that the ventilator was not switched off.	Preparations to turn off ventilator stopped. She got antidepressants.
2001, May		Ms B planned her rehabilitation and was “cheerful.”
2001, June to July	Referred to several spinal units. Bronchoscopy was performed and two more later. Mental capacity was reassessed but did not give a firm conclusion about her mental state.	She consented to the bronchoscopies A clinical psychologist was involved.
2001, August	Ms B requested reassessment of her mental capacity.	She had mental capacity to make decision about her treatment.
2001, September	Ms B made it clear in written and orally that she had never changed her mind that she wanted the ventilator withdrawn.	When not having mental capacity, she considered other possibilities.
2001, November to 2001, December	Ms B was reluctantly suggested a one-way weaning programme and offered referral to a weaning center. She feared the pain. Ms B refused a bed in a hospice.	She rejected.
2002, March	Ms B is competent to make all relevant decisions ... including the decision ... to withdraw from artificial ventilation... .She has had the mental capacity to make such decisions since August 8, 2001 and that she will remain competent to make such decisions for the foreseeable future.	
2001, February 16 to 2002, April 29	Ms B endured a total of 14.5 months tetraplegia with ventilator assistance	

Table 2. Factors Impacting Miss P's Life.

Date	Minus factors	Plus factors
1948-1956	Materially limited time in the postwar Finland with two polio outbreaks 1954 and 1956	Normal childhood as an energetic child with siblings
1956	<p>The first symptoms broke out in October one Saturday, but Miss P went to school at Monday and at Thursday night the tracheotomy was performed in ether anesthesia. Paralytic poliomyelitis with hypoventilation at 8 years of age. A total of 632 persons were subject to polio in Finland this year.</p>	
1956-1958 University Hospital	Very painful physical therapy. Ventilator weaning program many times a day (13 hr out of ventilator at most)	Parents (often father) allowed to visit frequently
1960	Four years in ventilator	Miss P was still thinking that she would walk in the future.
1958-1968 University Hospital	<p>Out of 7 children, 4 died at 6, 12, 15, and 16 years in same hospital room. Fears (lasted 7 years) of death and doctors, no help to work through these fear One nurse per room per 4 children. Emotionally available nurses disappeared. Attachment to nurse felt not allowed; Alienation from own family members took place. Too short holidays: 7 days per year up till the age of 16, thereafter 10 days per year. Days of mourning before each return to the hospital. The nurses spent too much time in their office. The clock dictated our activities. When I was sick and could not eat, also water was taken away.</p>	<p>Comrades of fate were available. Obligatory school with "old-fashion" demanding teacher. Celebrated her confirmation Hobbies and entertainments were available. The basics of porcelain painting were taught. This hobby became later her work. Scouting, window-shopping, visits to friends, cinemas, and exhibitions. Films were shown on a weekly basis at the ward. Good food</p>

(continued)

Table 2. (continued)

Date	Minus factors	Plus factors
1968–1995 Home care in parental residence 1968–2012	<p>I felt if I was a burden, because my helpers were working in my parents' home.</p> <p>I did not have access to invataxi; Wheelchair and ventilator did not fit into a small car.</p> <p>No kiln was available for porcelain paintings until 1980.</p> <p>"I had a dream about my own home but father opposed; after he died I was ready to move."</p> <p>After oral polio vaccine 1985, I could not breathe without ventilator long anymore.</p> <p>Transfer from capital to countryside is not always easy, although this took out of free will.</p> <p>I had 10 to 15 long-term helper; one 40 years.</p>	<p>Got out of hospital life. Normal life without time schedules</p> <p>Close family members and four godchildren.</p> <p>Countryside with cats</p> <p>Spent 5 weeks during 4 summers at summer house in the archipelago</p> <p>Sauna. Family celebrations</p> <p>Could read, draw, change letters</p> <p>Taxi for disabled persons was available from 1987</p> <p>"A ripening time"</p>
1995–2012 Home care: Own residence	<p>About 30 short-term young help-nurses left for their studies. Out of these 2 were men.</p> <p>If an unexpected problem with a helper arises, she cannot be dismissed after the trial period.</p> <p>Hospital limits autonomy by deciding when help-nurses come and go (7 to 8 hr)</p>	<p>A dream came true: Own independent life. Can paint porcelain as much as I like. Own kiln from 1997. Enough porcelain-painting orders. Invataxi travels available</p>
1999–2012	<p>Instructed help-nurses about ventilator use</p> <p>"The ventilator apparatus is not the main thing, the human being is!"</p>	<p>Achievements</p>

(continued)

Table 2. (continued)

Date	Tasks and comments	Achievements
2001–2002	Plans for first exhibition: “Porcelain painting can be implemented in very different ways . . . country-specific cultures and traditions impact the art. Golden edges, strong, thin, black borders or even a . . . story derives strongly from the culture . . .”	First porcelain exhibition
2003–2005	Several porcelain exhibitions: two as invited painter	Won 1. Prize 2004
2009	“Porcelain painting is a delicate and demanding work. You cannot be in a hurry and the item cannot be corrected after it has been in the kiln. Porcelain painting requires perseverance and concentration—these skills are also learned.”	Ms P is Artist of the Year 2009
2010–2013	“I’m always excited about new topics and ideas.”	Conducted morning assemblies about life in schools Presently attending Spanish lectures

Table 3. Quotes From Miss B and Miss P.

Date	Miss B: Short-term perspective on disability and attitudes	Miss P: Long-term perspective on disability and attitudes
2001	<p>“The one-way weaning programme involved titrated sedation...I would be given sedation ... just sufficient to deal with any anxiety I may have, so I could be managed that way. ... It did not involve any pain relief and it included hydration which I thought could extend my life. ... My concern was that I would have a very long and uncomfortable, possibly painful, passage because the programme, as proposed to me, was not to gradually withdraw the ventilator, but to reduce it to a level where my ventilation would be inadequate. ... That would provide a situation where I would then develop a chest infection and, possibly, other complications, and then I would die from those complications. ... So, without being too graphic, I would actually be waiting to become septic. I have seen that happen and I know it is slow and I know it is painful. ... I felt that if I was lightly sedated as part of the weaning programme, and I lay here for a period of weeks, I would possibly go quietly psychotic, quite frankly, apart from the physical discomfort. That just terrified me, the prospect of dying like that, really” BBC News, March 7, 2002</p>	<p>“I’ve always wanted to do things through perseverance. The desire to draw and paint was there before I became paralyzed. At first I felt that I was facing a wall and the track of the pencil ... was not very flattering. But through persistent training, topic after topic, arising from heart and soul, are marked on the porcelain surface. Each year has brought new ideas to my work”</p> <p>“When I was in my mother’s womb, she stayed for the last month in a religious family close to the maternity hospital. I think I got it from there. Since my childhood I have believed in God. ... After attracting polio I said in the hospital my evening prayer and blessed my family members.”</p>
2001	<p>“In many ways the decision to have my treatment withdrawn has been a very difficult one for me as I have been a Christian and a regular church attendee all my life. The dominant view in the church is that I should wait for God to heal me. Withdrawing ventilation would be seen as throwing in the towel. I have questioned myself about this and it has challenged my integrity. It has been a very difficult process to rationalize</p>	<p>“Of course this faith was sometimes tested, but I could never ask somebody to take my life and suicide did not cross my mind. I am put in this world to gain knowledge of something.”</p> <p>“My wisdom agrees with a part of The Lord’s prayer: ‘And forgive us our debts, as we also have forgiven our debtors.’”</p>

(continued)

Table 3. (continued)

Date	Miss B: Short-term perspective on disability and attitudes	Miss P: Long-term perspective on disability and attitudes
2002	<p>what I am doing in the context of my faith but I feel there is no alternative, as I do not have any realistic hope of recovery. I have come to believe that people die and become disabled and God does not always intervene.” (EWHC 429, 2002)</p> <p>“The way I see it, I had a job where I was head of department and we would have unusual things that we had never dealt with before—enormous press interest, which had huge ramifications—you deal with them. You are a senior manager and you deal with it. That is my experience. You certainly do not whinge to the client about how difficult it is for you. It is totally inappropriate.” (Laurance, 2002)</p>	<p>I embrace the Golden rule: “Do unto others as you would have them do unto you.”</p> <p>Miss P’s first porcelain exhibition: “The great happiness in life is to do exactly what the others think I’ll not be able to do”</p>
2002	<p>Miss B: “The trust has broken down for me [and the doctors] because I believe I have been deliberately misled and that they have been deliberately obstructive in allowing me access to doctors outside.” For instance I was told over and over again that no doctor would ever do this. Yet, through my own network of friends, I was able to identify several doctors who disagreed with that point of view. . . .” I was told that I was not being referred to a weaning clinic and, clearly, I had.” So, for the first time I started to think that this is not just an ethical disagreement, this is obstructive. “Of course, you do not care what people think when you are dead, but in a way you do because it goes towards your character and your integrity and I think it does matter.”</p>	<p>“I have not been bitter and God is my ultimate goal. My message to my fellow humans conveys God’s love to them and the joy of the possibility of this kind of life.”</p> <p>“This kind of life does not exclude romantic experiences”</p> <p>“Always better the more responsibility you can take for yourself”</p> <p>“You can always learn something new or refine what you already have learned. The attitude determines, and the ability to seize opportunities.”</p>
2002	<p>“Ms B subsequently exercised her right to refuse treatment and her death was reported on the 29th of April” (Slowther, 2002).</p>	
2009		<p>Artist of the year: “I am God’s favorite child”</p>

The Case of Ms B

Ms B's life, achievements, and fight to have the ability to make the fundamental decision whether to require the removal of the artificial ventilation keeping her alive—and whether she, herself, is legally competent to make that grave decision after subject to tetraplegia with ventilator assistance—are reformulated on the basis of what can be read out of the court *modus operandi* (EWHC 429, 2002). Details are provided in Table 1. On August 26, 1999, Ms B suffered a hemorrhage of the spinal column in her neck and a cavernoma was diagnosed, caused by a malformation of blood vessels in the spinal cord. She was transported to another hospital where she stayed for 5 weeks. The doctors informed her that there was a possibility of a further bleed, or surgical intervention, which would result in severe disability. As a result, she executed a Living Will (dated September 4, 1999) where she stated that in case she was not capable to give directions, she desired for treatment to be withdrawn if she endured a life-threatening condition, continuous mental impairment, or permanent unconsciousness. She was told that the risk of rehemorrhage was not big, and she was confident about the future. She got better and returned to work with some weakness in her left arm. In February 2001, she suffered an intramedullary cervical spine cavernoma and suffered complete paralysis from the neck down. Three days later, she was transferred to the intensive care unit (ICU) with respiratory problems and was ventilator dependent ever since. She did not want to be ventilated, but the doctors informed her that her Living Will did not authorize withdrawal of ventilation. In the end of March, she was subject to neurological surgery for the cavernous hematoma. Her condition improved slightly, she could move her head and articulate words, but she was bitterly disappointed in the operation so she asked for the first time for the ventilator to be switched off. Dr A, a consultant psychiatrist from another hospital, assessed Ms B, and she returned to ICU at the Hospital where she remained, and in the beginning of April, her solicitors gave formal instructions to the Hospital, via, that she wished the artificial ventilation to be removed. A case conference followed and two independent psychiatric assessments should take place. A few days later, she was assessed by Dr B, a psychiatrist, who concluded she had capacity, but Dr C then amended her report to state that Ms B did *not* have capacity, after which Dr B amended his original assessment so as to agree with Dr C. Ms B was prescribed antidepressants and was seen by two doctors 2 weeks later (For some people, it can take up to 8 weeks or longer before they start to feel better, and the maximum benefit is felt after 6 months; Sane, 2010). The doctors stated that Ms B was relieved that the ventilator had not been switched off, and 1 month later, Ms B participated in assessment for rehabilitation and agreed to try it. Plans were made for her rehabilitation, for her to eventually return home with 24-hr care, or alternatively a residential nursing home. Ms B was “very cheerful” and “upbeat.” She was referred to several spinal units. She received help, which is continuing, from a clinical psychologist.

She was reassessed 1 month later by Dr B and Dr C, but their assessments did not reach a conclusion as to her mental capacity. In the middle of July 2001, a bronchoscopy was carried out as part of treatment for a left lung collapse. At her request, an independent reassessment was conducted by Dr A in the beginning of August, who indicated that he did not consider Ms B to be depressed and that he considered her competent to make the decision to discontinue her treatment. Thereafter, the Hospital treated Ms B as having capacity to make decisions. In the middle of August, Ms B made a further Living Will, and in the middle of September, two further bronchoscopies were performed with Ms B's consent. She was suffering respiratory distress at the time. Between August 2001 and January 16, 2002, the Trust sought advice from various outside sources. The possibility of a one-way weaning programme was suggested by Dr D by which over a period of time the number of breaths supplied by the ventilator is step by step reduced, and the patient's body can get used to breathing on its own again. If the patient cannot manage on his/her own, the number of breaths is increased, but in a one-way weaning program, it is reduced without going back on again. Sedation is given without causing respiratory depression unless clinically indicated. The clinicians were not prepared to turn off the ventilator; they agreed on the one-way weaning program but with reluctance as an acceptable compromise. It was also agreed that this could be achieved either by sending Ms B to a weaning center or carrying it out in the ICU (EWHC 429, 2002).

In the middle of November, Ms B was offered access to a weaning center, which she refused. She was offered the program in the ICU but did not want it because the process would have lasted about three weeks, and because analgesics would have been omitted as part of the action. Ms B said in September 2001 that she refused a spinal rehabilitation unit and also declined a referral to one clinic when her name was near the top of the waiting list in October. She disagreed to have a bed in a hospice in December because the hospice would not have her ventilator withdrawn (EWHC 429, 2002). The request from Ms B would perhaps have been understood in a palliative care situation, but it was almost certainly outside the experience of the staff in the ICU had in relation to a mentally competent patient. It was seen by some as killing the patient or assisting the patient to die and ethically unacceptable (EWHC 429, 2002). Ms B would without the help of artificial ventilation have had a less than 1% chance of independent ventilation, and death would almost certainly follow. According to the judge:

My decision leaves Ms B with a future choice which she can consider freely now that she will be relieved of . . . litigation . . . she has the right to reflect on what she may wish to do with her life . . . I hope she will forgive me for saying, diffidently, that if she did reconsider her decision, she would have a lot to offer the community at large.

Ms B endured ventilator assistance for about 1 year and 2.5 months. Her mental competence and right to refuse life-saving treatment for no reason—rational or irrational—are issues that have been subject to much debate (Coleman & Drake, 2002; Goodman, 2004; Hamilton, 2002; Laurance, 2002; Slowther, 2002; Stauch, 2002; Tweeddale, 2002).

Analysis of Ms B's Search for Existential Meaning

Frankl (1988) admitted, based on his own horror in the Nazi KZ, that we can never be free from every condition, for instance an incurable disease, but we are able of resisting and braving even the worst circumstances. In doing such, we can detach ourselves from situations, that is, transcend it, choose our attitude about ourselves, establish our own determinants, thus determining our own character and becoming responsible for ourselves, because life has meaning under all circumstances, even under the most miserable ones. The main issue for the court was to reveal whether Ms B had the capacity to make her own decision about her treatment in hospital. Ms B was a gifted and talented woman of 43 who had suffered an overwhelming illness that had caused her to become tetraplegic, and her expressed wish was not to be kept artificially alive by the use of a ventilator (EWHC 429, 2002). According to Frankl, our main motivation for living is our will to find meaning in life. We have freedom to find meaning in what we do, and what we experience, or at least in the position we take when faced with a situation of unchangeable suffering. Frankl said “what is demanded of man is not, as some existential philosophers teach, to endure the meaninglessness of life, but rather to bear his incapacity to grasp its unconditional meaningfulness in rational terms.” In search for existential meaning, a person is led by his or her conscience; meaning in life can neither be given, nor created—it has to be individually discovered. Frankl (2009a) claims that suffering has a meaning only and solely under the circumstance that the cause of suffering cannot be removed. Under equal circumstances, those who have the greatest chance of survival in extreme conditions are those oriented toward the future; survival is best guaranteed in meaning orientation.

First, meaning in life can be discovered by creating a work or doing a deed in other areas than those lost through the hardship (Frankl, 1984). Ms B seemed to be on the search for a purpose or existential meaning, although a frustrated meaning, by eagerly pushing to be declared legally competent to make her own grave decision to be assisted to discontinue artificial life support in the name of patient's right to autonomy. The judge had to consider Ms B's ability to make the fundamental decision whether to require the removal of the artificial ventilation keeping her alive, but the judge was not requested to decide whether Ms B lives or dies, only to decide if Ms B is legally competent to make that grave decision. This case was not about the best interests of the patient but about her mental capacity (EWHC 429, 2002). This means that even if Ms B won her case,

she would not have to go along with a choice to die. She won the case against the hospital that did not consider her competent to make that kind of decision. However, Ms B stated:

I never changed my mind about wishing for the ventilator to be switched off with the inevitable consequence of death. Having expected the process towards death to be commenced, I was informed by the hospital that this would not now happen because of a change in psychiatric opinion that I no longer had capacity “I did have some sense of relief, but it was not the sort of relief like, ‘I am really glad I am alive’, it was a sort of relief *that I had a very difficult task ahead of me* At this stage I had not been assessed as having capacity so I agreed to giving rehabilitation a try” . . . rejected this option of rehabilitation as it offered no possibility of recovery. I had not *changed my views*; it is just that now I was assessed as being able to make a choice.

Second, existential meaning can also be completed by experiencing something or encountering someone (Frankl, 1984).

In many ways the decision to have my treatment withdrawn has been a very difficult one for me as I have been a Christian and a regular church attendee all my lifeWithdrawing ventilation would be seen as throwing in the towel. I have questioned myself about this and it has challenged my integrity. (EWHC 429, 2002)

According to Frankl, an “existential vacuum” is at hand when one’s life is depleted of meaning which state gives way to existential depreciation with the core thought “Life is of no value,” in other words, no life is of value, in contrast to depression with the core thought “I am of no value” (Boeree, 2006). The focus in court was put on mental capacity, depression, eventually regression, decision-making capability (EWHC 429, 2002) but not on disappointments and interpretations instigating existential crisis with subsequent existential vacuum. Ms B’s two major disappointments impacted her mind: (a) The neurological surgery for her hematoma after which she for the first time asked the ventilator to be switched off; (b) Ms B expected a miracle because her interpretation of her church was that she should wait for God to heal her. In a state of existential vacuum, one also feels cynical, lacks direction, and questions the point of most of life’s activities (Frankl, 1984). Furthermore, Frankl’s second suggestion for search for meaning also included love. Ms B disclosed that:

It has also been difficult for me to contemplate leaving the people I love behind. There has been a lot of talking and crying as no one wants me to die but almost all of them empathize with me and my situation and sincerely wish to respect my wishes, which I have made clear to all.

Ms B claimed that she was repeatedly told that no doctor would ever switch off her ventilator, but she was able to identify several doctors who would. She started to think that this was not just an ethical disagreement but obstruction. Yet, Ms B refused the option of a switch that she could operate herself to turn off her ventilator. “To her [the goddaughter] the notion that her godmother chose to commit suicide would be painful, and . . . because I love her, it matters to me” Ms B’s love would have enabled her to see the essential qualities, features, and potential in her goddaughter. By making the girl aware of what she can be and of what she should become, Ms B could have guided her goddaughter’s potentialities to come true (Frankl, 2010). By means of a Socratic dialogue, Ms B could have discovered the value of love and of being a *role model in suffering* for her goddaughter (Fabry, 1996).

Frankl’s third suggestion for finding an existential meaning when confronted with an unchangeable fate includes an attitudinal change toward inevitable suffering (Frankl, 1984). Ms B: “I cannot accept myself as disabled and dependent – it’s too big a leap to make. The totality of dependence is intolerable.” We complete existential meaning in life by our ability to turn inevitable suffering into human success. Discovering an individual existential meaning is facilitated by “self transcendence”—that is, raising above one’s own self:

Being human always points, and is directed, to something, or someone, other than oneself - be it a meaning to fulfill or another human being to encounter . . . The more one forgets himself - by giving himself to a cause to serve, or another person to love - the more human he is and the more he actualizes himself. (Frankl, 1975)

Consequently, an attitudinal change is facilitated through self-transcendence, and there are hints that Ms B had the capacity for self-transcendence by detaching herself by means of humor. According to the judge, Ms B: “has retained a sense of humor and, despite her feelings of frustration and irritation which she expressed in her oral evidence . . . she appears to me to demonstrate a very high standard of mental competence, intelligence and ability.”

A Hypothetical Existential Analytic/Logotherapeutic Discourse With Ms B

Without guidance and assistance of somebody familiar with logotherapy, a search for meaning can be unsuccessful due to existential frustration and the risk that the patient engages in responses harmful to himself and others (Frankl, 1984; Zaiser, 2005). Socratic questioning, or maieutics (Beck, 1995), deals with painful thoughts through *revealing* the issue, *conceiving alternatives*, *examining potential consequences*, *evaluating the consequences*, and *distancing*. A Socratic dialogue with Ms B’s could be as follows:

Revealing. Ms B, what evidence supports the idea that you have to refuse treatment if you are assessed to have the mental capacity to have the right to make your own decisions about future medical treatment? What evidence supports the meaningless of a ventilator-assisted life? What evidence supports the idea that you can accept rehabilitation for your condition?

Conceiving alternatives. Did church attending benefit you in a previous situation when you felt loss of control, helplessness, and depression? Your church's view is that you should wait for God to heal you. What other views relative to illness is presented by your church? What does "God heals" mean to you? Is there another viewpoint of what is meant with "healing"? Imagine that you have to give a speech in your church on the courage to choose a ventilator-assisted life. What would you say?

Examining potential consequences. What would be a bearable outcome for you of surviving as a ventilator-assisted tetraplegic? What is the consequence of having your goddaughter to emphasize with your decision to die? How is your goddaughter going to recover from your death? What happens if she cannot overcome your death?

Evaluating the consequences. What happens if you are not holding onto this belief that your only option for a fulfilling life is death? What does "complete recovery" mean to you? Is there any alternative to "complete recovery"? What could be the effect of thinking differently and no longer holding onto this belief of complete recovery?

Distancing. Imagine that your goddaughter is a ventilator-assisted tetraplegic what would you like to tell her? Would you advise her to withdraw life support? Would you tell her that her life is meaningless?

The Case of Ms P

Ms P was subject to paralytic poliomyelitis with hypoventilation in 1956. Ms P is paralyzed from the neck down and ventilator-assisted from the age of 8 years (Table 2). Routine immunization with polio vaccine for children was initiated in Finland in 1957. Spinal polio results from viral invasion of the motor neurons of the anterior horn cells, or the ventral grey matter section in the spinal column. Approximately 19% of all paralytic polio cases have both bulbar and spinal symptoms which type is called respiratory and bulbospinal polio; the virus affects cervical vertebrae C3 through C5 and paralysis of the diaphragm occurs. The phrenic nerve and those that drive the muscles needed for swallowing are affected, and this form of polio affects breathing, making it difficult or impossible for the patient to breathe without the support of a ventilator

(Poliomyelitis, 2013). Ms P gave her informed consent in written to participate in the present interview, which was undertaken in October 16, 2012 for 5 hr in her home. The interview was a semistructured, in-depth conversation at a date of her choice. No paid attendant was present in the room, and notes were completed during the interview and corrected when repeated over phone at several occasions during a 2-week period of time. Open-ended questions and probes such as “can you tell me about the time for the tracheotomy?” were given. Ms P spent 12 years at university hospital where four youngsters died at the age of 6, 12, 15, and 16 years. This instigated fear of death in Ms P, who also suffered from fear of doctors for about 7 years. Only one person of the staff per room with four youngsters was available. Normal obligatory school was on hand. Hobbies as well as entertainments were accessible. The basics of porcelain painting were taught. Holidays were spent at home: 7 days per year up till the age of 16 years, thereafter 10 days per year. Traumatic separations from home took place on a yearly basis. Between 1968 and 1995, home care was arranged in parental residence, but Ms P felt that her helpers burdened her parents. After oral polio vaccine in 1985, Ms P’s condition deteriorated. Postpoliomyelitis syndrome (PPS or postpolio sequelae) is a condition that affects approximately 25–50% of people who have previously contracted poliomyelitis of the nervous system—after the initial infection. Characteristically, the symptoms emerge 15 to 30 years after recovery from the original paralytic attack, at an age of 35 to 60. Symptoms include acute or increased muscular weakness, pain in the muscles, and fatigue. There are currently no entirely defined causes of PPS (PPS, 2013). Ms P could not breathe long without ventilator anymore. Wheel chair and ventilator did not fit in a small-sized car, but Invataxi (cab for injured persons) big enough for these aids became available from 1987. Finally in 1995, home care in own residence was achieved. “I had a dream about my own home but father opposed; after he died I was ready to move.” Her dream came true: own independent life. Porcelain painting became her work. Own kiln was available from 1997. In 2001, she planned her first porcelain exhibition and in 2002 she opened it. In 2004, she won first prize. In 2009, she was appointed Artist of the Year.

Analysis of Ms P’s Search for Existential Meaning

Frankl’s (1984) *first* suggestion for a path to an existentially meaningful life comes to pass through creativity. Ms P demonstrates long-term creativity in her porcelain painting, although she lacked means for several years until she traded an interview for a kiln. Ms P opened her first exhibition in 2002, and the exhibition was well received. Ms P continues to paint and enough orders are at hand. She received first prize for tableware 2004. She surprised the public when they heard that she painted by mouth. Ms P was appointed “artist of the year 2009” and received a monetary reward.

Frankl's (1984) *second* suggestion for an existentially meaningful life comprises the experience of something or someone inspiring, such as the beauty of nature or culture. Ms P stresses the importance of culture in her art. She also points out the value of education, after 12 years of hospital care under the supervision of an "old-fashion" demanding teacher, who laid the foundation for language studies in her later life. Frankl also pointed out that existential meaning can be realized through love for a special person or family member, or through the value of close friends. In the hospital, Ms P valued the opportunity to have comrades of fate, despite the fact that she lacked the prospect to get guidance in daily living from a grown up. Ms P lacked explanations, for example, why water was taken away from her together with food, when she felt too sick to eat. In the hospital, help-nurses and trained nannies spent time with the patients; the nurses spent more time in their office. As regards relationships to family members and friends from home, they lived hours away from the capital. However, Ms P and her close ones kept in contact by phone, letters, and for the most part by her father visits. Yet, after years at the hospital, Ms P enjoyed the parental home care and the opportunity to spend time with family, friends, four godchildren, and animals. She also met that special one. About love and her relationships with that special person she adds:

This kind of life does not exclude romantic experiences . . . It is wonderful to move smoothly in the castles of blur of love and to feel worthy of love. Even if a lost love hurts me as much as it would hurt anybody else . . . All these events have strengthened me mentally, I hope. What doesn't kill you makes you stronger.

Ms P lacked the opportunity to discuss death in the presence of three out of four deaths of her mates in the very same room! The hospital chaplain did not bring up death either. Even the girl Ms P was to celebrate her affirmation of baptism with, died before the celebration took place. In Ms P a strong fear of death took root and lasted for years. Frankl says that in order to understand death and life's ephemeral nature, one must first understand the nature of time and that time only goes in a single direction. He notes that as an individual understands the full gravity of time, he or she will recognize the full responsibility for living. The meaning of human existence is based upon its irreversibility. An individual's responsibility in life must therefore be understood in terms of temporality and singularity. When Frankl (1961, 1984, 1988, 1997) claims that we can derive from life's transitory nature an incentive to take responsible action, Ms P says:

the feeling that the authorities possess me and take a lot of responsibility away from me, sometimes strikes me. I want to take responsibility and be responsible for my own life. Always better the more responsibility you can take for yourself.

Frankl's *third* suggestion to experience an existentially meaningful life includes "identifying value in unavoidable suffering" by an attitudinal change toward the unalterable situation. Ms P claimed that it took her *at least* 4 years to fully grasp her dilemma. However, she adjusted to the situation and persevered in her dream to have a home of her own. She had to face and conquer many obstacles, besides her disability and disapproval from her father, before the dream came true. Through the patience and perseverance learned through the porcelain painting process, and from painting mistakes that could not be erased when they came out from the kiln, she knew how to succeed. Ms P claims "You can always learn something new or refine what you already know. The attitude determines, and the ability to seize opportunities." It is obvious that Ms P chooses and has adjusted her attitude toward the situation.

Ms P's capacity to surrender to self-transcendence in her creative motives can be discerned. The motives often tell a story about a couple surrounded by nature in different settings. Ms P's capacity to surrender to self-transcendence is also there through remembering and dreaming about a loved one, and it helps her momentarily to rise above her difficulties in her daily life. When asked about her thoughts about guilt Ms P says: "what lies behind me, is in the past . . . we need to live in a way we do not have to regret . . . we do not need to repeat our mistakes but to learn from them." She is whole-heartedly and actively involved in life. She is a religious person with a strong faith. According to Frankl (1997), a weak faith is weakened by predicaments and catastrophes, whereas a strong faith is strengthened by them. A religious person is not satisfied with just a meaning to complete but takes a step forward by including divinity as a supra or ultimate meaning in life. "In the creative work the artist is dependent on sources and resources deriving from the spiritual unconscious," and Frankl (2009b) continues that we recognize the ultimate meaning of life on rather existential than intellectual grounds. Ms P has spent in her opinion a fulfilling life as a tetraplegic ventilator-assisted person for 57 years.

Discussion

We have presented the cases of two women, Ms B in United Kingdom and Ms P in Finland, as to their attitudes and individual ways of addressing inescapable suffering in the form of paralysis from the neck down with ventilator assistance. The year 2002 came to constitute a turning point for both of these ladies: One of them wins the right to make her decision to refuse ventilator assistance, and the other opens her first exhibition of mouth-painted tableware. Existential analysis/logotherapy was called "*height psychology*" because it endorsed the idea that people could transcend natural processes (Pytell, 2003) and focuses on the future aspects of his/her life, particularly on the meaning that life urges us to fulfill (Boeree, 2006). On the other hand, Tweeddale (2002) states that: "Difficult

though it is, the competent patient is the only one qualified and authorized to make decisions about his or her ‘best interests.’” Frankl (1961, 1992) does not go along with this line of thinking; as a survivor of four concentration camps, he knows that humans are capable of resisting and braving even the worst conditions through self-transcendence by detaching oneself, at least momentarily, from the situation. We know that Ms B had the ability for self-transcendence through humor, which was also shown in court, as a form of self-detachment (Frankl, 2009a; 2009b).

To discover that there was any semblance of art in a concentration camp must be surprise enough for an outsider, but he may be even more astonished to hear that one could find a sense of humor there as well; of course, only the faint trace of one, and then only for a few seconds or minutes. Humor was another of the soul’s weapons in the fight for self-preservation. It is well known that humor, more than anything else in the human make-up, can afford aloofness and an ability to rise above any situation, even if only for a few seconds.

Ms P reveals her capacity for self-transcendence in her creative motives that tells a story, often about a couple in different surrounding or settings and in her dreams about loved ones. Self-transcendence refers to the interest people have in searching for something elevated, something beyond their individual existence. Cloninger (2013) says that self-transcendence “manifests as an intuitive understanding of superior aspects of humanity, like compassion, ethics, art, and culture”; it may also be an awareness of a divine presence. People with capacity for self-transcendence lose awareness of their separateness when absorbed in what they love to do with the experience of self-forgetfulness and transpersonal identification. This corresponds to Freud’s “oceanic feelings,” explained as a primary ego-feeling coexisting along with the ego as the feeling of limitlessness the infant has before it learns there are other persons in the world (Oceanic Feeling, 2013). Cloninger (2013) proposed in agreement with Frankl that self-transcendence is an essential component in the processes of integration and maturation of personality enhancing a sense of well-being, as measured by presence of positive emotions, absence of negative emotions, contentment with life, or virtuous behavior. One of existential analysis/logotherapy affirmatives says that we are mind, body, and spirit as autonomous parts of the self. The spiritual core, and only the spiritual core, guarantees and constitutes oneness and wholeness; it permits us to exercise our will to meaning, to visualize our goals, and to move beyond our instinctual and sexual needs to self-transcendence (Krasco, 2005).

Frankl (1984) revealed that what really matters in inescapable suffering is the attitude or change of attitude we courageously choose or have to adopt, when subject to extreme situations. The capacity for transcendence facilitates this. Frankl states, however, that we always have the freedom to find a meaning in

life even if only by finding a meaningful attitude in a hopeless situation in agreement with Jaspers (1971) who spoke of “limit situations” where our humanity is defined when we confront ourselves in a distressing way and make us true to ourselves and our lives. The therapeutic value of Frankl’s existential analysis lies in the disclosure of an individual’s concrete existential situation and in assistance in the person’s autonomous search for meaning (Batthyany, 2013). We shall help people to ask themselves in these limited situations how they can proceed in another and perhaps more desirable direction (Jaspers, 1971). For example, Jerry Long became paralyzed from the neck down in an accident that ended his baseball career. He wrote a letter to Viktor Frankl and they became friends. Long became a psychologist and logotherapist and often lectured together with Frankl to audiences around the world (Long, 2008). Thus, in order for a person to find meaning after he or she has been subjected to unavoidable suffering, means that values embedded in this suffering need to be identified. This can be achieved by courageously adopting an attitude or change of attitude in such a circumstance, as Long put it “I broke my neck but my neck did not brake me.” Yet, the search for meaning can be facilitated by the assistance of someone familiar with existential analysis/logotherapy. Frankl (1984) claims that freedom is not the last word. It is only a part of the story and “half of the truth.” Freedom is the negative aspect of the observable fact whose positive aspect is responsibility. Freedom can degenerate into mere randomness unless it is framed by responsibility.

Ms B was left with only 1 year and 2.5 months of tetraplegia with ventilator assistance. This period of time seems in retrospect to have been too short for an attitudinal change to such a grave dilemma to take place without the help from a logotherapist. It took Ms P in her own words *at least* 4 years to adjust on her own to the fact that she was a ventilator-assisted tetraplegic and to grasp that she would not walk again. From this perspective, Ms P had *enough time* in coming to an acceptance of her dependency. She changed her attitude, that is, she fulfilled attitudinal values in an extreme situation, and accepted that she would never walk again. In contrast, Ms B idealistically demanded either to be fully recovered or dead. Yet, she was liked by the staff at her hospital ward and cared for in the best of ways according to the protocol, and it was difficult for staff to understand that she had no vision of a future (cf. Lützén, Cronqvist, Magnusson, & Andersson, 2003; Lützén & Ewalds-Kvist, 2012). Conversely, Ms B’s will to meaning was frustrated; this *existential frustration* led her to a search for a meaning that was harmful for herself and those close to her. Coleman and Drake (2002) said that it seemed that Ms B was not questioned concerning emotional matters as the amount of visitation by her loved ones, and how that might have changed over time. This oversight revealed both ignorance of and disinterest in severely disabled people’s experience and factors that might instigate hopelessness and despair leading to suicidal feelings. Suicidal feelings

stem from a sense of meaninglessness, an existential frustration along with an existential vacuum, but the impulse to commit suicide might well be overcome, if the person has a vision of meaning to life (Frankl, 2009a; 2009b). Frankl (1992) states that we as humans are urged not only to act in a responsible manner, but also with full awareness of our actions.

Ms P was a child when she arrived at the hospital and in need of substitutes for stable parental guidance as well as of proper explanations for why certain events and care measures were undertaken. Her mind was repeatedly subjected to severe traumas when four of the other children out of which three resided in the same hospital room, died; she could not verbalize her fears of death and doctors, which fears took years to fade off. However, her distressing youth made her grow as a person. Nevertheless, presently Ms P's ability to achieve some independency is compromised by the hospital obligating her attendants to come and go at 7- to 8-hr intervals. Her autonomy and decision-making capacity in such trivial daily issues is neglected. Ms P stresses that her adjustment process to a different kind of life taught her that not only physical but also psychological, religious, spiritual, and intellectual needs have to be addressed. By addressing such needs, the patient's orientation toward an existentially meaningful future is improved. In contrast, respect for Ms B's autonomy and mental competence as well as her decision-making capacity weighed heavily as an argument for letting her make her final decision about life and death.

Frankl (1984, 1992, 1997) sees even in situations characterized by seemingly lack of freedom such as being subject to paralysis with ventilator assistance, that we always possess an inner freedom of choosing our response to the situation because the human being is a whole that includes body, mind, and spirit. Although the physical body is paralyzed, the spiritual core remains healthy, given that the path to the noëtic core stays unblocked. What keeps a person healthy is the tension between "to be" and "to become." Furthermore, the human being has the potential to move from inevitable suffering, the "tragic triad"—pain, guilt, and death—to the "tragic optimism" by making the best out of unavoidable adversity. We fulfill meaning in life by our ability to turn suffering into human triumph. Life's negative aspects can be turned into something positive: (a) by revolving [inescapable] suffering into an achievement; (b) by deriving from guilt the opportunity to transform oneself for the better; and (c) by drawing from life's transitory nature an incentive to take meaningful responsible action (Frankl, 1984, 1988). Frankl quotes Dostoevsky: "There is only one thing I dread: not to be worthy of my sufferings." And continues:

These words frequently came to my mind after I became acquainted with those martyrs whose behavior in camp, whose suffering and death, bore witness to the fact that the last inner freedom cannot be lost. It can be said that they were worthy of their sufferings; the way they bore their suffering was a genuine inner

achievement. It is this spiritual freedom—which cannot be taken away—that makes life meaningful and purposeful.

Today, Ms P unveils existential meaning and addresses the questions life poses to her by fulfilling her unique vocation as a porcelain painter.

Limitation and Implication of the Study

A limitation of this study is that we have not been able to interview Ms B, which means that there is a difference in the quality of the basic data. In an interview, follow-up questions can be posed that enrich the data. Based on our analysis, the implication of our study is that professional care providers could become acquainted with existential analysis/logotherapy and, for example, through Socratic maieutics assist the person to recall those values that previously were helpful in stressful “limit” or extreme situations where he/she felt overwhelmed, mourned, lost control, and felt depressed, to assist him/her to triumph over the existential vacuum (Beck, 1995). And more importantly, to facilitate the individual’s attitudinal change and responsible actions as a start in building up a path to an existential meaning orientation toward his/her future. A person’s ability for self-transcendence can be reinforced, let it be through day-dreaming, films, recollection of something enjoyable and good, bringing back loving memories to smooth the progress of detachment in the form of moments—minutes or seconds—of braving and rising above the inescapable suffering. It is imperative that a person in an extreme condition separates him/herself from his/her predicament; he/she is more than his/her dilemma.

Conclusion

Both Ms B and Ms P became acutely ventilator-assisted and paralyzed from the neck down but exhibited opposite reactions to their grave predicament. The reactions of these two women were analyzed in the light of Frankl’s existential analysis/logotherapy. What have we learned from their stories? First of all, expectations of complete recovery may be unrealistic. Hopes of returning to a passed position may be idealistic. Time may not be offered for a change of attitude on one’s own toward an overwhelming disaster. Assistance for an attitudinal change may not be on hand. However, every life—also that one in severe circumstances—has a chance to become existentially meaningful along three paths: creative values, experiential values, and by a change of attitude toward unavoidable suffering. One has to become worthy of one’s suffering! Furthermore, if any one of these pathways is obstructed in some manner, a person may not experience a meaningful existence and therefore does not pursue a will to survive. He/she exhibits a frustrated existential meaning along with an existential vacuum and despair that may be averted and redirected for a

recovered meaning orientation toward the future by applying the basic tenets of an existential analytic/logotherapeutic approach developed in and for brutal conditions by Viktor E. Frankl.

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