Integrating Logotherapy with Cognitive Behavior Therapy: A Worthy Challenge

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Matti Ameli

Introduction

Logotherapy, developed by Victor Frankl in the 1930s, and cognitive behavior therapy (CBT), pioneered by Aaron Beck in the 1960s, present many similarities. Ameli and Dattilio (2013) offered practical ideas of how logotherapeutic techniques could be integrated into Beck's model of CBT. The goal of this article is to expand those ideas and highlight the benefits of a logotherapy-enhanced CBT. After a detailed overview of logotherapy and CBT, their similarities and differences are discussed, along with the benefits of integrating them.

Overview of Logotherapy

Logotherapy was pioneered by the Austrian neurologist and psychiatrist Viktor Frankl (1905–1997) during the 1930s. The Viktor-Frankl-Institute in Vienna defines logotherapy as: "an internationally acknowledged and empirically based meaning-centered approach to psychotherapy." It has been called the "third Viennese School of Psychotherapy" (the first one being Freud's psychoanalysis and the second Adler's individual psychology). Frankl (1995) viewed logotherapy as an open, collaborative approach that could be combined with other psychotherapeutic orientations. He presented logotherapy as a complement to psychotherapy, not a substitute.

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Fundamental Tenets of Logotherapy

Tridimensional View of the Human Being: Intentionality

Logotherapy envisions man in three overlapping dimensions: somatic, psychological, and spiritual. Frankl defines the human spirit as "uniquely human" or what distinguishes human beings from other animals. He refers to the spiritual dimension as "noetic" to avoid religious connotations.

The noetic dimension is the site of authentically human phenomena such as humor, love, or gratitude. Frankl points out that in contrast with the first two dimensions where our reactions are often automatic, in the third dimension *we can choose how to behave* (Lukas 1998). Intentionality is the key factor in this case. For example, one can decide to express love or avoid hatred in spite of the situation. This is what makes human beings unpredictable. As Lewis (2011a, b) explains, Frankl calls this unpredictable quality "the defiant power of the human spirit."

Frankl (1959/1984) illustrates this concept that he was able to observe even in the concentration camp: "…there was always choices to make. Every day, every hour, offered the opportunity to make a decision, a decision which determined whether you would or would not submit to those powers which threatened to rob you of your very self, your inner freedom; which determined whether or not you would become the plaything of circumstance, renouncing freedom and dignity to become molded into the form of the typical inmate." In summary, the human person makes an intentional decision of who he/she is and who he/she wants to become every minute of his life.

Meaning and Freedom of Choice

In contrast with Freud's "will to pleasure" and Adler's "will to power," Frankl's theory is based on the premise that human beings are motivated by a "will to meaning," an inner pull to discover meaning in life. According to Frankl (1969) and as described by Ameli and Dattilio (2013), the three main principles of logotherapy are:

Freedom of will: human beings are not fully determined because they have the freedom to choose their response within the limits of given possibilities, under all life circumstances. They are not "free from" their biological, psychological, or sociological conditions but they are "free to" take a stand toward those conditions. There is always an "area of freedom" and the option of choosing one's attitude remains available.

Will to meaning: the main motivation of human beings is to search the meaning and purpose of their lives. Human beings are capable of sacrificing pleasure and supporting pain for the sake of a meaningful cause or person.

Meaning in life: life has meaning under all circumstances, even in unavoidable suffering and misery. Meaning in life is unconditional and human beings have to

discover it "in the world" and not to invent it. Frankl (1959/1984) insists that life has meaning in spite of suffering but only if that suffering is unavoidable. If it were avoidable, then removing its cause would be the meaningful thing to do.

As described by Ameli and Dattilio (2013), we can discover meaning in life in three different ways known as the categorical values: creative, experiential, and attitudinal. The creative value consists of what we give to the world like accomplishing a task, creating a work, or doing a good deed. The experiential value is what we take from the world like the experience of truth, beauty, and love toward another human being. It could be actualized through nature, culture, art, music and literature, and through loving relationships. The attitudinal value reflects the stand we take toward an unchangeable situation or unavoidable suffering. As Lewis (2011a, b) describes, the attitudinal value is actualized when "one chooses bravery over cowardice, mercy over revenge, or justice over appeasement."

Actualizing the attitudinal value is key to face adversity or bear with an unchangeable destiny and as Frankl (1959/1984) points out: "to turn a predicament into a human achievement or personal triumph." A meaningful life is a life where the three categories of values are actualized to the highest possible degree (Lewis 2011a, b).

The following statement perfectly illustrates the main logotherapeutic principles and values described previously:

> "We who lived in concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken away from a man but one thing: the last of the human freedoms—to choose one's attitude in any given set of circumstances, one's own way" (Frankl 1959/1984).

When the will to meaning is frustrated or blocked and a person is incapable of finding meaning or purpose in his/her life, he/she will experience a sensation of emptiness, hopelessness, or despair that Frankl (2003) calls *existential vacuum*. Some of the symptoms of that condition include apathy and boredom, and it may lead to aggression, addiction, depression, and possibly *noogenic neurosis*. Frankl (2004) defines *noogenic neurosis* as a clinical condition where the psychological symptoms are a result of existential or spiritual conflicts. Since in this case the root of the neurotic problem is in the third "noetic dimension," Frankl proposes logotherapy as the specific therapy for the treatment of that category of neurosis.

Responsibility

In logotherapy, responsibility is considered the essence of human existence. Being human means taking responsibility to deal with life's challenges through our actions and behaviors. Frankl (1959/1984) explains that we are not the ones who should ask something from life; we are questioned by life on a daily and hourly basis and "our answer must consist, not in talk or meditation, but in right action and in right conduct."

Applying the concept of responsibility in clinical practice consists of:

- Helping the client to become fully aware of his/her sense of responsibility. He/she is the one who has to decide for what, to what, or to whom he/she is responsible, based on his/her own understanding. The therapist should not impose value judgments or act as a "preacher" (Frankl 1959/1984).
- Taking into account that the client is not a "victim" but the "coauthor" of his/her destiny (Lukas 1998). Therefore, he/she is also responsible for his/her own recovery through the therapy process. One of the principals of the logotherapeutic process is: you have to bring help but without taking away responsibility (Lukas 1998).

Self-transcendence

In contrast with Maslow's theory, defining self-actualization as man's ultimate need, Frankl proposes the concept of self-transcendence. He declares: "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. What is called self-actualization is not an attainable aim at all, for the simple reason that the more one would strive for it, the more he would miss it. In other words, self-actualization is possible only as a side-effect of self-transcendence" (Frankl 1959/1984). In summary happiness can't be pursued; it's a buy-product of self-transcendence. Interestingly, Maslow arrived at a similar conclusion: "Self-actualization is not the highest human need; self-transcendence is the ultimate need of the human soul" (Pattakos 2004).

Use of Healthy Inner Resources

According to logotherapy, every person has a healthy core and the goal of the therapist is to help the client discover his/her intact, healthy forces and strengths, and use them in order to overcome his/her problems. Logotherapy focuses both on the client's "current positives" (assets and strengths) and "future potentials" or possibilities for expansion (Lukas 1998). Frankl believes in "overestimating" the person so he/she can achieve his/her highest potential. He says with Goethe: "if we take man as he is, we make him worse, but if we take man as he should be, we make him capable of becoming what he can be." He considers the above maxim as crucial for all psychotherapeutic intervention.

The two healthy resources mainly used by logotherapy are: self-distancing (ability to detach from oneself and set a distance between self and the symptoms) and self-transcendence (Lukas 1998). Sense of humor is another important human asset appealed to by logotherapy.

Tragic Optimism

According to Frankl (1959/1984) "tragic optimism" is the ability to remain optimistic in spite of the "tragic triad" of pain, guilt, and death. This is based on the principle that life is meaningful under any circumstance and the human capacity to make the best of any given situation by creatively turning negative aspects into positive and constructive ones. Optimism including the triad of hope, faith, and love could be used to face tragedy by: "(1) turning suffering into a human achievement and accomplishment; (2) deriving from guilt the opportunity to change oneself for the better; and (3) deriving from life's transitoriness an incentive to take responsible action" (Frankl 1959/1984). Frankl insists that optimism cannot be commanded; one needs to discover a reason for optimism, a meaning.

Goals and Therapeutic Process

Frankl (1959/1984) declares that logotherapy is "neither teaching nor preaching." He compares the role of the logotherapist to an ophthalmologist who enables the person to see the world as it is, thus considering logotherapy as an objective therapy. He explains: "the logotherapist's goal consists of widening and broadening the visual field of the patient so that the whole spectrum of potential meaning becomes conscious and visible to him" (Frankl 1959/1984). Frankl (1959/1984) quotes Lukas, saying "throughout the history of psychotherapy, there has never been a school as undogmatic as logotherapy."

Frankl proposed logotherapy as the "specific" therapy for noogenic (or existential) neurosis and as a "nonspecific" or collaborative therapy for other types of neuroses. Referring to that second category Frankl (1995) explains that logotherapy is a real therapy for attitudinal change; rather than focusing on symptoms, it facilitates the change of posture of a patient in regards to his/her symptoms.

Considering the main tenets of logotherapy, the goal of the logotherapist would be to tap into the unique human capacities such as intentionality, responsibility, and freedom of choice to help the client discover and actualize the meaning potentials in his/her life. In summary, logotherapy is an objective, active, collaborative, and action-oriented form of therapy, where the client (as long as his/her noetic dimension remains open) is held responsible for his/her recovery process in therapy as well as for his/her life, through his/her personally meaningful attitudes, decisions, behaviors, and actions. The client is always free to decide no matter what his/her circumstances are and in spite of his/her biological or psychological limitations; therefore he/she is not considered a "victim" nor is he/she exempt from responsibility.

Techniques of Logotherapy

The three main techniques used in logotherapy are: paradoxical intention, dereflection, and attitude modification.

Paradoxical Intention

Description and Use

Paradoxical intention was first used by Frankl in 1929. This technique is based on self-distancing through the use of humor. The client is asked to expose himself/herself to his/her worst fear by wishing with humorous exaggeration the very thing that provokes his/her greatest fear or anxiety. For example, in the case of a person who has panic attacks and fears a heart attack: "I am going to have five heart attacks today." Paradoxical intention counteracts anticipatory anxiety (it's not possible to fear something and wish strongly for it to happen) and thus breaks the anxiety vicious circle. It is illustrated in detail by Dattilio (1987, 1994). Paradoxical intention has been used mostly in cases of panic disorder and agoraphobia, and also in the framework of family therapy (Ameli and Dattilio 2013).

The central components of paradoxical intention include: "(a) a nonmanipulative therapist-client partnership, (b) ruling out biological etiology, (c) educating clients about paradoxical intention with regard to what it is and how it works, (d) tailoring the technique to the individual's presenting complaints, (e) participating in the fear state, while (f) simultaneously incorporating humor to counteract anxiety" (Schulenberg et al. 2008).

Lukas (1981) describes the first step of paradoxical intention as self-distancing from the symptoms through humor followed by a change of attitude and symptom reduction.

Frankl points out many of the similarities between paradoxical intention and behavioral techniques such as exposure, flooding, or satiation. He refers to behavior therapists such as Dilling, Rosefeldt, Kockott, and Heyse, who argue that although not developed in the frame of the learning theory, paradoxical intention is possibly based on similar mechanisms underlying behavior modification techniques such as exposure therapy techniques (cf. Frankl 1995, 44). According to Ascher (1989) some of the behavioral techniques, mainly implosion and satiation, are simply "the translation of paradoxical intention."

The use of humor is the essence of paradoxical intention and what distinguishes it from behavior modification techniques. This inclusion of the sense of humor as an intrinsically human characteristic in logotherapy adds a substantial advantage compared to many of the techniques in behavior therapy (Frankl 2004). Humor is a healthy human resource directed only toward the symptom, not the client. Hutzell (Fabry 2010) points out that humor allows the individual to distance himself from his behavior and become aware that other aspects of one's life are more significant than the symptom behavior. This intervention helps to reduce anticipatory anxiety, as well.

Research

The first attempt to validate paradoxical intention was conducted by behavior therapists. Ascher (1978–1979) points to the first pilot study conducted by Solyom, Garza-Pérez, and Ledwige (1972) studying ten patients who complained of recurrent

compulsive thoughts. Applying the technique of paradoxical intention helped to reduce or eliminate the target symptom for five of the subjects. For the remaining subjects studied, three presented with unchanged symptoms and two failed to apply the technique appropriately (cf. Ascher 1978–1979, 18).

Ascher and Efran (1978) employed paradoxical intention to five cases of onset sleep insomnia were resistant to behavioral treatments. The results indicated that all five cases "experienced the immediate reduction of sleep onset latency and further attention to this problem was terminated after 2 or 3 weeks" (Ascher 1978–1979). Further studies by Asher and associates confirm that paradoxical intention is a clinically effective technique for clients presenting with sleep disruption (Ascher 1978–1979).

Levinson (1979) also reports a case of insomnia that was successfully treated with paradoxical intention.

A recent review of 19 clinical outcome studies on paradoxical intention was conducted by Fabry (2010). The studies were selected among articles published between 1966 and 2009 using the following criteria: publication in a scholarly journal, quantitative research methodologies, presence of pre- and post-intervention, and enrollment of participants in a paradoxical intention program. The author concluded: "positive results were yielded for all but 1 out of 19 outcome studies with no adverse effects reported. It can be seen that paradoxical intention is supported by the empirical research data as a therapeutic method" (Fabry 2010, 24). The author further points out that paradoxical intention was integrated successfully into the cognitive behavioral protocol two decades previously (Fabry 2010).

Paradoxical intention has been validated empirically for sleep disorders, agoraphobia, and public speaking anxiety, mainly in the presence of recursive anxiety (Schulenberg 2003).

In terms of clinical intervention, Frankl has presented various cases of clients suffering from obsessive–compulsive disorder and agoraphobia that were treated successfully and in a short period of time, using paradoxical intention (Frankl 1995, 2004). Dattilio has integrated behavioral techniques with paradoxical intention. He proposed paradoxical intention as an alternative to symptom induction and relaxation, especially in cases where there is a risk of undiagnosed cardiac disease or seizure disorder and in patients who might be prone to experiencing relaxation-induced anxiety (Dattilio 1987, 1994).

Marshall Lewis, a logotherapist and clinician trained in CBT, describes the case of a patient diagnosed with obsessive compulsive disorder who was suffering from intrusive thoughts of blasphemy and received 3, 1-h sessions of paradoxical intention (Lewis 2011a, b). In the third session, the patient received a combination of the specific strategy that Frankl had developed to apply paradoxical intention to patients presenting intrusive thoughts of blasphemy, and relaxation training based on Wolpe's techniques (Lewis refers to Frankl explaining that combining paradoxical intention with relaxation has been successful). The results show that "when combined with relaxation training, the symptoms remit by the end of the third session. The patient remains symptom-free at a 6-week follow-up appointment" Lewis (2011a, b). He concludes that the result obtained using paradoxical intention in a clinical setting is consistent with the research literature.

In conclusion, paradoxical intention appears to be a valid and effective technique that can be integrated well into a CBT framework. Its complimentary component serves to broaden the scope of treatment.

Dereflection

Description and Use

The technique of dereflection was developed by Frankl shortly after World War II. It is based on self-transcendence, described above. As highlighted by Ameli and Dattilio (2013): "The dereflection technique counteracts hyperreflection which could be defined as an over-focus or dwelling on a problem or a symptom that makes it worse or a compulsive tendency toward self-observation. Dereflection shifts the client's attention away from the symptom and reorients it towards another person or a motivating/meaningful area."

Frankl (2004) explains that while paradoxical intention trains the client to "make fun" of his neurosis, dereflection helps a client ignore his symptoms. Lukas (1998) defines dereflection as disregarding something that may possibly become worse through reflection. She insists that dereflection is more than a distracting strategy; it's reaching beyond oneself and rebuilding self-transcendence. She refers to this as a "recipe against egocentricity" (Lukas 1998).

The dereflection technique was originally developed for sexual disorders. The client is instructed to ignore the ruminative thoughts (this breaks the hyperreflection) and focus on meaning (Lukas 1998). For example, in the case of impotence due to excessive self-observation, there is a recommendation for abstinence during a period of time, and the client is asked to focus on giving love, attention and tenderness through caresses, and understanding to his partner. As a result, the patient's sexual capacity regenerates and he eventually breaks the abstinence rule.

According to Lukas (1981), the four steps in the dereflection process are: (1) self-transcendence, (2) finding meaningful tasks and goals, (3) symptom reduction, and (4) change in attitude. She highlights that in dereflection, discovering meaningful goals and tasks serves as therapeutic itself because the client's attention is focused away from "what's wrong with me" to "what's right with me."

Dereflection has been applied to a variety of problems such as insomnia, swallowing and speech disorders, depression, rumination, fear of failure, and narcissism (Frankl 2004; Lukas 1991, 1998; Rogina 2004). It has also been used successfully in couple therapy (Schulenberg et al. 2010). Ameli and Dattilio (2013) provide an example of how dereflection could be incorporated in the CBT protocol for depression.

Research

The dereflection technique is an important part of the sexual therapy model proposed by Frankl in 1947. His model predated Masters and Johnson's sexual therapy model, developed in 1970 (Ameli and Dattilio 2013). William S. Sahakian and

Barbara Jacquelyn Sahakian share the opinion that Masters and Johnson's investigations validated Frankl's treatment protocol and results for sexual disorders (cf. Frankl 1995, 65).

Ascher (1980) notes that, before Frankl's focus on the use of dereflection for certain sexual dysfunctions, the treatment plan for those disorders lacked direction and a consistent positive outcome. He points out that although many components of the Masters and Johnson sexual therapy model were based on data derived from their own research, significant aspects of their therapeutic programs did not originate with them, but had previously appeared in the professional literature; among them "dereflection" and Wolpe's desensitization techniques. He adds: "It does not seem unreasonable that these therapeutic components were responsible for much of the clinical success reported by Masters and Johnson." (Ascher 1980, 13).

In terms of clinical intervention, Frankl reports specific cases of clients who were treated successfully with dereflection, in a brief period of time, mainly for sexual and sleep disorders and also for autonomic psychomotor dysfunctions such as swallowing and speech problems: the attention is redirected to "what" to eat or to say instead of "how" to do it, the autonomic part (Frankl 1995, 2004). Lukas reports successful results using this technique with problems such as depression, rumination, and fear of failure (Lukas 1991, 1998).

At a metacognitive level, it is worth noting the resemblance between dereflection and some of the attention techniques included within the frame of Metacognitive Therapy (MCT), developed by Adrian Wells (Wells 2009). According to MCT, psychological disorders are maintained because of the individual's unhelpful) thinking style referred to as CAS (Cognitive Attention Syndrome). Wells (2009) defines CAS as a "toxic" style of thinking, found in all disorders, "consisting of worry/rumination, threat monitoring, unhelpful thought control strategies, and other forms of behavior (e.g., avoidance) that prevent adaptive learning." The CAS locks the person into prolonged and intense periods of negative emotional experience. It is mainly characterized by self-focused attention and self-related topics. The Attention Training Technique (ATT) is used to redirect the attention away from excessive and persistent self-focused activity, a key element in worry and rumination, and to strengthen the client's control over the focus of his/her attention. It is important to note that ATT is not a distraction or avoidance technique that involves shifting the client's attention to neutral or positive events. Rather, it is based on the use of auditory stimuli within a specific procedure. Clients are asked to direct their attention, as instructed, to the auditory stimuli while regarding the unwanted thoughts and feelings as additional noise. They should not block or resist them, but rather follow the procedure and let those intrusive thoughts take care of themselves (Wells 2009).

The concepts of hyperreflection and CAS are comparable since they both are characterized by an excessive self-focused attention. Although there are theoretical and practical differences between ATT and dereflection, the main goal of both types of techniques is to counteract excessive self-focus and remove dwelling and rumination, by ignoring the unwanted thoughts and feelings. One idea would be to combine both techniques: redirect the client's attention away using ATT and then

refocus and "lock" it into a personal meaningful aspect (tasks, goals, people, etc.,), using dereflection. This could be accomplished by incorporating personally meaningful words (related to tasks, goals, projects, or other people) or sounds (nature, music, animals, etc.,) within the ATT protocol, in addition to neutral auditory stimuli.

Attitude Modification

Description and Use

The term of "attitude modification" was proposed in 1980 Elisabeth Lukas, student of Frankl's (Lukas 1998). Through Socratic dialogue, the client explores personally meaningful values, motivations, perspectives, areas of freedom, choices, and available meaningful options or actions. It is essentially a guided discovery process.

Unlike behavior modification, logotherapy's focus is to first modify the attitude because modifying an internal attitude leads effortlessly to a modified behavior (Lukas 1998). The goal of attitude modification is to help the client improve his/her attitude in regard to "something" and activate the will to meaning. In order to deal with the existential vacuum (the client is unable to perceive value and meaning in life) and to train the client in "meaning sensitization," Lukas (1998) proposes the following steps: (1) define clearly the problematic behavior (what is my problem?), (2) define the areas of freedom for action in spite of apathy, boredom etc. (where is my area of freedom?), (3) draw upon the client's imagination to list all possible options (what are my options?), (4) select the most meaningful options based not on pleasure but on the imagined consequences for all parties involved (which option is the most meaningful?), (5) ask the client to implement the most meaningful option that he has chosen in spite of his/her condition (lack of motivation, fear etc.).

Lukas (1980) explains that to modify negative or destructive attitudes, common sense is often used as a guideline. When the client displays an unhealthy attitude, the therapist questions it and helps the client discover all of his/her available choices. The goal is to help the client to become aware of his/her personally meaningful values hierarchy so that he/she can actualize those values. The therapist doesn't "prescribe" attitudes and doesn't decide if an attitude is "correct" or "moral," but rather facilitates a reflection for the client.

When faced with unavoidable suffering or unchangeable and negative external factors (the "tragic triad": suffering, guilt and death) the client still has the choice to adopt a new attitude toward his/her situation. To help the client actualize the attitudinal values, consistent with Frankl's "tragic optimism," Lukas (1998) describes the following procedure based Frankl's guidelines:

(1) Show the value: this consists of showing that maintaining a positive attitude in a tragic situation is commendable because it reflects the capacity of the human spirit to resist and to turn suffering into personal triumph; (2) show the meaning: help clients realize that there is some positive aspect to their situations in spite of the suffering. Lukas recommends some caution with this strategy because the "positive in spite

of the suffering" could be discovered more easily by the non-affected than the affected person; (3) show the rest: indicate the available positive opportunities that are not affected by suffering and should not be affected by it. It's "saving the rest" without substituting the loss; (4) show perspectives: tactfully offer perspectives that could help "soften" the situation, based on "logophilosophy." For example, all suffering is a process of growth, a maturing opportunity through which one comes to see more value in life's luxuries and people whom he/she loves. Guilt is an opportunity to learn, compensate and actualize forgiveness. Finally, death is a reminder that life is finite. Therefore, it is important to take advantage of the meaningful opportunities that it offers us every day and to implement our projects without procrastinating.

In summary, the goal of the attitude modification technique is to correct negative attitudes by transforming them into meaningful actions, experiences and attitudes. This technique could be used for issues such as guilt, loss, grief, suffering, serious diseases or terminal illnesses, neurosis, and depression.

Lukas (1998) explains that with anxiety disorders such as phobia, although the somatic symptoms cannot always be controlled or regulated, the client is free to decide how to react and respond: taking it seriously, ignoring it, escaping, or persevering in the situation in spite of his/her fear. The therapist can motivate clients to go through the exposure process by exploring their "free areas" or choices (tapping into that third human dimension) in order to facilitate a shift from: "I am a slave to anxiety or fear" to "I am the master and I choose to not allow fear to paralyze me." Ameli and Dattilio (2013) describe an example of attitude modification with a client suffering from generalized anxiety.

In summary, Lukas describes the three techniques listed above as a change of how the client responds to the external world (by changing his internal view): paradoxical intention corrects the anxious expectation, dereflection corrects the focus of attention, and attitude modification corrects the negative attitude.

Another interesting technique to consider is *the Values Awareness Technique* (VAT) developed by Hutzell and Eggert (1989/2009). It's a pen and pencil format and the goal is to help people discover their personally meaningful values hierarchy (based on Frankl's categorical values), define meaningful goals for short, intermediate and long term, and align them with their values. It could be used to facilitate dereflection and define meaningful goals at the end of the CBT depression protocol (Ameli and Dattilio 2013).

Research Data on Logotherapy

Background

Frankl was aware of the importance of quantitative, evidence-based studies and encouraged researchers to conduct scientific research on logotherapy. As a neurologist, he was very interested in empirical research and validation. He expressed it specifically (Batthyany and Guttmann 2006):

> You cannot turn the wheel back and you won't get a hearing unless you try to satisfy the preferences of present-time Western thinking, which means the scientific orientation or, to put it in more concrete terms, our test and statistics mindedness […]. That's why I welcome all sober and solid empirical research in logotherapy, however dry its outcome may sound (Fabry 1978/1979, 5–6).

A large number of research studies have been conducted to validate the main concepts, constructs, and tools used in logotherapy as is evident by more than 600 studies listed by Batthyany and Guttmann (2006).

Although there is still a need for further assessment and refinement of research tools to evaluate the therapeutic value of logotherapy, the authors conclude: "we may say with all due respect and modesty, that Frankl would have been very pleased to find that the research in logotherapy has far surpassed his dream" (Batthyany and Guttmann 2006).

Psychometric Assessment

A variety of psychometric tools have been created to quantify the life-meaning-construct. The earliest and most investigated one is the PIL (Purpose In Life Test) developed by Crumbaugh and Maholick in 1964. It contains 20 items with a seven-point likert-type response format and measures the degree to which a person experiences a sense of personal meaning (Schulenberg and Melton 2008).

In terms of validity, based on a number of studies and reviews, the PIL shows positive correlations with constructs such as self-control, life satisfaction, extroversion, self-acceptance, and emotional stability, and correlated negatively with anxiety, depression, and boredom proneness. Those results are consistent with logotherapy's postulate and research studies showing the association between life meaning and well-being (Schulenberg and Melton 2008).

In terms of PIL's reliability, the alpha-coefficient is ranging from 0.86 to 0.97. It can be concluded that the PIL is a relevant research tool in the area of meaning. Schulenberg envisions the PIL as a potential instrument that could be included in a battery of psychological measurement tools to "highlight clients' strengths" (Schulenberg and Melton 2008).

It has also been shown that meaning in life has discriminative power: it can distinguish between clinically distressed and not distressed subjects and also between clinical population and those with no mental illness (Schulenberg and Melton 2008).

A recent study (García-Alandete et al. 2009) using the PIL and the hopelessness scale (Beck et al. 1979) shows a statistically significant negative correlation between life meaning and hopelessness, confirming the hypothesis that existential vacuum is associated with high levels of despair. Taking into account that hopelessness is a powerful suicide risk predictor, the authors suggest that the concept of existential vacuum could be considered a significant predictor of moderate to high suicide risk. In contrast the sense of purpose and life meaning indicates a minimum suicide risk.

Those findings support the mathematical equation that Frankl proposed to illustrate the concept of despair: D (despair) = S (suffering) – M (meaning).

In addition to PIL, other existing tools for the measurement of meaning and meaning-related concepts are: The Life Purpose Questionnaire (LPQ), the Seeking of Noetic Goals Test (SONG), the Meaning In Suffering Test (MIST), and the Life Attitude Profile-Revised (LAP-R).

Theoretical Base of Logotherapy

Frankl defines logotherapy as both "existential" and "phenomenological." One of the major influences on the development of logotherapy is the phenomenology of Max Scheler (Lewis 2011a, b). Other influential philosophers are Karl Jaspers and Martin Heidegger, emphasizing the concepts of responsibility and freedom of action (Lukas 2008).

It is also important to highlight that Frankl's personal experience in the Nazi concentration camps has influenced the concepts of his logotherapy. He was able to validate some of them by observing in a real and extreme setting the behavior of human beings. The concentration camp was his "natural" laboratory. One of his conclusions is that meaning has survival value: those prisoners who were oriented toward the future, toward a task or a meaning to fulfill had a higher chance of survival (Frankl 2003). These results were confirmed by American psychiatrists based on data from the wars with Japan, Vietnam, and Korea (Frankl 2003).

One aspect that makes the foundation of Logotherapy unique in comparison with other types of therapies is the fact that its founder validated the main concepts of his approach through his real-life experiences, in some of the most extreme, tragic, and cruel circumstances in the history of humanity. Frankl remained the authentic model of his theory and teachings until his death (Klingberg 2001; Ryan 2008).

Overview of CBT

Cognitive therapy was developed by the psychiatrist Aaron T. Beck in the early 1960s. While conducting experiments to validate the fundamental psychoanalytic concepts of depression, he was surprised to find the opposite. As a result of those findings, Beck et al. (1979) proposed a new clinical approach to depression based on the concept of "automatic thoughts" about oneself, the world, and/or the future. He called this new approach "Cognitive Therapy" and it has also become known as "Cognitive Behavior Therapy" (CBT).

The Beck Institute defines cognitive therapy as: "a comprehensive system of psychotherapy and treatment based on an elaborated and empirically supported theory of psychopathology and personality." Since its introduction, Beck's model

has been expanded by researchers and several variants of cognitive therapy have been proposed.

CBT is empirically based and has been proven effective by hundreds of outcome studies for a wide variety of psychiatric disorders such as: depression, the full range of anxiety disorders, substance abuse, eating disorders, personality disorders, and bipolar disorder and schizophrenia (in combination with medication). It is also used for problems such as: low self-esteem, anger management, relationship difficulties, and grief/loss. CBT has broad applications and is used effectively with children, adults, couples, families, and groups.

The Cognitive Behavior Model

Cognitive therapy is based on a cognitive theory of psychopathology and the importance of information processing. According to that model, people's perceptions or thoughts about situations (cognitions) largely determine their emotional and behavioral reactions.

When an individual is distressed, his/her perceptions and thoughts become distorted and this leads to dysfunctional behaviors and emotions. In addition, according to Beck et al. (1979), the beliefs or assumptions an individual has of himself/herself, the world and others are based on previous experiences and if they are distorted, they could also give rise to dysfunctional thoughts. Through CBT, clients learn to identify, evaluate (against objective data and facts), and modify their "automatic thoughts" (spontaneous cognitions), assumptions, and beliefs so their thinking becomes more realistic and adaptive. The therapeutic change occurs at three interactive levels: cognitive, behavioral, and affective. The cognitive change facilitates behavioral change by allowing the client to adopt a risk taking perspective and in turn putting into practice the new behaviors helps to validate that perspective. Emotions can be moderated by considering alternative interpretations of the situation (based on objective evidence and facts) and in turn emotions influence cognitive change, given that learning is more prominent when emotions are triggered (Beck and Weishaar 1989). CBT puts emphasis on thoughts in both initiating and maintaining therapeutic change.

Cognitive change happens at three levels and the therapist works with the client at those three levels (Dattilio and Padesky 1990). (1) *Automatic thoughts* are the most accessible surface thoughts. They are images or beliefs that are situations specific (e.g., "my wife is late, she doesn't care about my feelings" or the image of her having a good time with her friends). (2) *Underlying assumptions* are more generalized and conditional rules that help us structure our perceptions. They are at a deeper level and underlie automatic thoughts (e.g., "you can't count on women for support"). (3) *Schemas* are inflexible unconditional core beliefs (e.g., "I will always be alone"). Those three levels are interconnected and the goal is to produce change at all three levels.

It is important to highlight that although thoughts are emphasized, CBT is an interactive model where thoughts, emotions, behaviors, environment, and biology can each influence the others (Dattilio and Padesky 1990).

Goals and Therapeutic Process

According to Beck and Weishaar (1989), "the goalsof cognitive therapy are to correct faulty information and to modify dysfunctional beliefs and assumptions that maintain maladaptive behaviors and emotions." Besides achieving the remission of the disorder, relapse prevention is also emphasized in the frame of CBT.

Both cognitive and behavioral techniques are utilized in CBT and the client is taught the following throughout the treatment process: (1) to monitor his/her negative automatic thoughts (cognitions); (2) to recognize the connections between cognition, affect, and behavior; (3) to examine the evidence for and against his/her distorted automatic thoughts; (4) to substitute more reality-oriented interpretations for these biased cognitions; and (5) to learn to identify and alter the dysfunctional beliefs which predispose him/her to distort his/her experiences. (Beck et al. 1979).

A strong therapeutic alliance is a key element of CBT. The therapist and the client collaborate as a team and set the goals for therapy and the agenda for each session together.

The two main strategies used are collaborative empiricism and guided discovery (Beck and Weishaar 1989). Through collaborative empiricism, the client takes up the role of a "scientist" and tests the validity of his/her thoughts and beliefs against objective data and evidence (gathered by both himself/herself and the therapist). Through the process of guided discovery, the therapist serves as a guide to help the client clarify his/her problematic thoughts and behaviors and setup behavioral experiments to test hypothesis based on those thoughts and behaviors.

In terms of dialogue, a gentle Socratic questioning style is usually used to help clients identify, evaluate, and respond to their automatic thoughts and beliefs.

CBT is an active, structured, action-oriented, and time-limited approach. Homework assignments play a key role: clients are taught to become their "own therapist" through the acquisition and practice of cognitive, behavioral, and emotional regulation skill.

According to the Beck Institute, CBT is generally short term and the structure of a session includes the following: "a mood check, a bridge between sessions, prioritizing an agenda, discussing specific problems and teaching skills in the context of solving these problems, setting of self-help assignments, summary, and feedback."

It is also important to note that CBT is present oriented: although an evaluation of the past origin of the problem is conducted, the main focus is to eliminate the present maintaining factors.

Theoretical Base of CBT

CBT has been mainly influenced by three sources (Beck and Weishaar 1989):

– The phenomenological approach rooted in Greek Stoic philosophy, Kant's work (conscious subjective experience), and the writings of Adler, Alexander, Horney, and Sullivan;

– The structural theory: mainly Freud's conceptualization of cognitions into primary and secondary processes; and
– Cognitive psychology: primarily based on the model of "personal constructs" of Kelly and the work of Richard Lazarus on the role of cognitions in behavioral and emotional change.

Behavior therapist such as Bandura, Mahoney, and Meichenbaum have also made important theoretical contributions. It is also important to note that the work of Albert Ellis in Rational Emotive Behavior Therapy (REBT) has provided impetus to the development of CBT (Beck et al. 1979).

Comparing CBT with Logotherapy

As seen earlier, there are similarities between behavior modification techniques and logotherapeutic techniques such as paradoxical intention and research has validated paradoxical intention, and deflection within the model of sexual therapy. Frankl (2004) points out that logotherapy anticipated many features that were validated later on through solid experimental research by behavior therapy.

Frankl (2000) describes the emergence of behavior therapy as a "healthy and reasonable" trend in comparison to psychoanalysis that has made a valuable contribution to psychotherapy by demystifying neurosis. Comparing both approaches, he conceives behaviorism as a therapy of "reactions" and logotherapy as a therapy focused on "action" that goes beyond behaviorism, without contradicting it (Frankl 1969). He uses the example of an airplane: the fact that an airplane can fly doesn't contradict its capacity to move on the ground like a car (Lewis 2011a, b). It's important, however, to point out that Frankl refers to behaviorism (first wave) in his writing and not to CBT (second wave) as used today.

Lukas (2006) refers to the cognitive element that has allowed behavior therapy to move beyond conditioning. She believes that CBT has an exact and scientifically objective foundation and is efficient and valid in the psychological dimension. In the same way, she points out, that logotherapy is efficient and valid in the noetic dimension. She highlights that since there isn't a rigid line that separates the psychological and noetic dimensions, there shouldn't be one either between CBT and logotherapy; but rather a "fruitful symbiosis" between these two important orientations (Lukas 2006). She points out that the future of CBT and logotherapy depends on the motivation of their respective representatives to complement each other and combine the two orientations.

Similarities and Differences Between CBT and Logotherapy

CBT and logotherapy present many similarities:

– They have both been influenced by phenomenology.

- They both emphasize that modifying internal maladaptive "attitudes" (Beck refers to attitudes or schema) leads to behavioral change.
- Both are active, participative, action-oriented, and collaborative approaches (between the client and the therapist) and use a process of "guided discovery" without the therapist imposing his/her personal concepts of reason or meaning.
- The therapeutic alliance is important in both approaches.
- The Socratic dialogue is the main conversation tool and both make use of imagination.
- Both approaches are sound, brief, and solutions focused. The use of common sense is a key factor.
- Their main goal is to resolve the present issue, not explore the past.
- Both approaches take into account empirical research and use valid tools and pragmatic techniques.

There are also major differences:

- Logotherapy goes beyond learning principals, reinforcement, and cognition. It takes into account the "unique" human dimension where authentic human phenomena such as self-distancing and self-transcendence reside.
- Referring to that third noetic dimension, the concepts of intentionality, freedom of choice, meaning, and responsibility are central to logotherapy but absent in CBT. In that dimension, a person can choose how to behave.
- Humor (defined as intrinsically human) is an integral part of the exposure methodology in logotherapy (paradoxical intention).
- The main focus of logotherapy is to discover life meaning and purpose (which would lead to the "correct" attitude) versus modifying only erroneous thinking patterns in CBT.
- Logotherapy is value based and puts emphasis on personal meaning in a broad sense and not in purely intellectual or rational terms.
- Logotherapy taps into the healthy, intact part of the client, the positive, and helps him/her discover and use his/her strengths.
- Logotherapy is a positive form of psychotherapy and CBT is a "coping" model: the goal of logotherapy is to increase well-being and not only to overcome a disorder like in CBT.

In summary, logotherapy and CBT have a similar therapeutic process. Logotherapy doesn't dispute the empirical results and procedures used in CBT; however, it goes beyond by taking into account the third, noetic, dimension.

Benefits for Combining CBT and Logotherapy

CBT and logotherapy compliment each other: CBT as a psychotherapy is very much a "coping" model. In this respect, the CBT model compliments the principles of logotherapy. As a positive therapy, logotherapy in turn adds the noetic dimension and focuses on well-being, going beyond rationality and disorder resolution.

Ameli and Dattilio (2013) have presented through specific examples the benefits of integrating the concepts and techniques of logotherapy with CBT at the clinical level. Those benefits are presented below along with additional ones:

- The concept of freedom of choice could be valuable at several levels: (1) in the exposure procedure it could motivate the client to face anxiety or fear by making him/her see it as an option; he/she can't control his anxiety level but can choose how to react: run away or stay in spite of the fear; (2) it could facilitate perceptual shifts and action by eliminating excuses rooted in the past: one is free to choose new behaviors in spite of his/her past learning history and conditionings; (3) in case of unavoidable suffering (terminal or incurable illness, grief, loss, etc.,), integrating the attitudinal choice (one is free to take a stand, including the discovery of meaning in suffering) into the cognitive protocol could help the client to better accept and bear with pain and suffering, minimizing the risk for depression, despair, and suicide (Ameli and Dattilio 2013).
- The use of humor in the exposure procedure helps in reducing anticipatory anxiety (Ameli and Dattilio 2013).
- Combining the PIL and VAT with cognitive behavior instruments could help assess the risk for suicide and help clients take steps toward building a meaningful life at the end of therapy (Ameli and Dattilio 2013).
- Using the concept of "intentionality" helps differentiate between the cause and the reason, which in some cases get mixed up in CBT. Frankl uses the example of love and hate as "human phenomena" because they are intentionally directed toward a person or an object. Human beings have always motives to love or hate and their behavior is rooted in a reason and not only a biological or psychological cause that urges or pushes them to act aggressively. At the human level, one can choose, for example, to avoid or overcome aggression.
- Integrating the concept of responsibility has multiple benefits: (1) it can motivate the client to take the CBT process seriously and own their progress and results; he/she is responsible for his cure as the decision maker of his/her life; (2) using the logotherapeutic principle that one is not a victim but the "cocreator" of his/her destiny could better counteract the "victim" or the "martyr" schema; (3) it could stimulate the client to better analyze his/her choices and take responsibility for his/her errors in order to adopt new interpretations and behaviors.
- Adding the concepts of personal values and meaning could make the therapy process more individualized and effective, and allows working with a broader range of clients.
- Increasing well-being through hope and optimism leads to a proactive and resilient attitude that could improve relapse prevention.
- A few authors have pointed out the value of enhancing cognitive behavior therapies with logotherapy and existential–phenomenological therapies:

- Corrie and Milton (2000) insist on a strong case for connecting existential and cognitive models and suggests that adding the concept of value to the cognitive model offers a "framework through which it is possible to explore the choices we make about who we are and who we want to become."
- Lukas (2006) points out the benefit of combining both approaches at the therapeutic level so that therapists could work with the complete tridimensional (somatic, psychological, and noetic) representation of the human being.
- Hutchinson and Chapman (2005) highlight the "remarkable similarities" between Rational Emotive Behavior Therapy (REBT) and logotherapy. They point out that: "logotherapy-enhanced REBT can facilitate reciprocal and comprehensive alterations of both rational processes and core existential schema."
- Along the same lines, Lewis (2009) promotes a meaning-centered REBT approach, generating both rational and meaningful cognitions and attitudes that would lead to self-transcendence. He also points out that adding the concept of personal meaning could increase the client's motivation in completing the homework assignments in cognitive behavior therapy (Lewis 2009).
- Losa Grau (2009) reports the benefits of combining cognitive behavior therapy with logotherapy through her research with support groups dealing with the loss of a close relative: the process of meaning recreation and discovery helped participants to reflect on the positive meaning that the death of their loved one had for them and value what really mattered in their life.
- Hutzell (2009) points out that logotherapy complements cognitive behavior therapy on several powerful and validated variables such as: "client variables, therapist variables, and technique variables."

Conclusion

Integrating logotherapy with CBT is a worthy challenge because it could add value at all levels: client's motivation and well-being, therapeutic process efficiency, effectiveness, and relapse prevention. Logotherapy opens that third "human" dimension and broadens the scope of treatment: not only are the dysfunctional reactions and thoughts modified but intentional, responsible, and meaningful actions are promoted and the client is capable of creating purposeful goals which will increase his/her well-being and resilience at the end of therapy. Suffering is minimized while well-being is maximized.

Moving toward a logotherapy-enhanced CBT or a meaning-based CBT would be beneficial for both approaches: CBT could take advantage of valid tools and techniques in the noetic dimension and logotherapy could benefit from a valid and empirically based model in the psychological dimension.

It would be desirable for experts in CBT and logotherapy to collaborate in order to design integrative protocols that would provide the most efficient and effective treatment plans.

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