Reason, Meaning, and Resilience in the Treatment of Depression: Logotherapy as a Bridge Between Cognitive–Behavior Therapy and Positive Psychology

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Matti Ameli

Introduction

The concept of meaning has generated interest in past years. Its understanding, definition, and functionality differ between different schools of psychotherapy. Meaning as defined within logotherapy's framework could be a potential link between cognitive-behavior therapy and positive psychology.

After offering an overview of Beck's model of cognitive-behavior therapy, positive psychology and logotherapy, including their respective views of the concept of meaning, the similarities and differences between logotherapy and both Beck's model of cognitive-behavior therapy and positive psychology will be highlighted. The role of meaning as a bridge between cognitive-behavior therapy and positive psychology, along with ideas for integrating the three approaches, will be discussed and an integrative model for depression will be presented. The chapter concludes with reflections regarding the benefits of a broad and holistic integrative approach to psychotherapy.

Overview of Cognitive-Behavior Therapy

Various forms of cognitive-behavioral therapy have been proposed. The rational emotive behavior therapy (REBT) pioneered by Albert Ellis in 1955 and the cognitive-behavior model developed by Aaron T. Beck in the early 1960s are two well-known approaches (Beck, 1995; Martínez, Rodríguez, Díaz del castillo, & Pacciolla, 2015). This chapter will focus on Beck's model due to its flexibility, wide range of applications, and substantial empirical support (Beck, 1995; Beck & Haigh, 2014).

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The Cognitive-Behavior Model

According to the model, people's perceptions or thoughts about situations largely determine their emotional and behavioral reactions. Through cognitive-behavior therapy (Beck, Rush, Shaw, & Emery, 1979; Beck & Weishaar, 1989), clients learn to identify, evaluate (against objective data and facts), and modify their automatic thoughts, assumptions, and core beliefs so their thinking becomes more realistic and adaptive. This process is called cognitive restructuring. 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 & Weishaar, 1989).

Cognitive-behavior therapy is empirically based and has been proven effective by a large number of clinical trials for a wide variety of psychiatric disorders (Beck, 1995; Beck & Haigh, 2014).

Therapeutic Process

A strong and sound therapeutic alliance is a key element of cognitive-behavior therapy (Beck, 1995). The therapist and the client collaborate as a team and set the goals for therapy as well as the agenda for each session together. Beck (1995) highlights the importance of a warm, caring, empathetic, and genuine therapeutic relationship.

The two main strategies used are collaborative empiricism and guided discovery (Beck & 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. Through the process of guided discovery, the therapist serves as a guide to help the client clarify his/her problematic thoughts and behaviors and set up behavioral experiments to test hypotheses based on those thoughts and behaviors. A gentle Socratic questioning style is usually used to help clients identify, evaluate, and respond to their automatic thoughts and beliefs. The Socratic questioning consists of a series of open-ended questions to help clients take distance toward their dysfunctional thoughts and explore objective evidence to evaluate them. A variety of other techniques are also used based on the client's individual case conceptualization and goals.

Cognitive-behavior therapy 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 skills (Beck, 1995). Beck's model is flexible and open to techniques from other orientations.

The Generic Cognitive Model (GCM)

Recently, an updated and broader model called the generic cognitive model (GCM) has been proposed by Beck and Haigh (2014). At the theoretical level, the new model includes additions such as the continuity between adaptation and maladaptation, a theory of modes (self-expansive and self-protective), dual information processing (automatic and reflective), schema activation, and attentional focus. At the applied clinical level, the generic cognitive model is based on four interacting components: situation, biased belief, focus, and maladaptive behavior. The applied model could serve as a template for clinicians to develop a rapid case conceptualizations for a variety of clinical settings. Beck and Haigh (2014) suggest that the optimum therapeutic intervention is one that focuses on each of the four clinical components.

For belief interventions, cognitive restructuring and behavioral experiments are mainly used. Focus interventions include a variety of cognitive, behavioral, and attentional strategies. Mindfulness-based interventions are also included as part of those interventions. Behavioral interventions generally use behavioral methods along with cognitive restructuring. Beck and Haigh (2014) believe the generic cognitive model has the potential to be the only empirically supported theory of psychopathology, since its components could be easily subjected to empirical investigation.

Meaning in Cognitive-Behavior Therapy

In the frame of the cognitive-behavior approach, meaning is primarily viewed as a cognitive process to develop a rational view of the self, others, and the world. Through the therapeutic process, clients are taught to identify the meaning they attach to their erroneous thoughts and beliefs (e.g., Client: “I can’t do this”. Therapist: “what does that mean for you?” Client: “I am inadequate”), evaluate that meaning against objective data and come up with a rational alternative. Meaning is used to make sense of and understand at the intellectual level, with the aim of developing realistic and adaptive thinking.

In recent years, importance has been given to the concept of values, especially within the schizophrenia treatment protocol. The latest *recovery-oriented cognitive therapy* (Perivoliotis, Grant, & Beck, in press) highlights the importance of combining cognitive-behavior therapy with a humanistic approach in order to help clients discover their key core values and improve their daily lives by engaging with the world. The updated cognitive-behavior therapy for psychosis referred to as *recovery and strengths-oriented cognitive behavior therapy for psychosis* (Wright et al., 2014) integrates concepts from third wave approaches. The goal is to enhance strengths and work toward values and a more meaningful life. This model goes beyond the rational and coping model.

Overview of Positive Psychology

Positive psychology is a new empirically based scientific movement introduced by the psychologist Martin Seligman in 1998. It is defined as "the scientific study of positive experiences and positive individual traits, and the institutions that facilitate their development" (Duckworth, Steen, & Seligman, 2005, p. 630).

Positive psychology categorizes happiness into three domains that are neither exclusive nor exhaustive: the pleasant life, the engaged life, and the meaningful life (Seligman, Rashid, & Parks, 2006). The pleasant life consists of having positive emotions such as satisfaction, joy, fulfillment, hope, faith and optimism, about the present, past, and future. It represents the hedonic theories of happiness. The engaged life is using one's positive traits such as strengths and talents, engaging and getting absorbed in work, leisure, or intimate relations. The meaningful life consists of using one's strengths for a higher purpose, to serve something considered bigger than oneself. Positive psychology techniques are used to enrich each of these three domains. A "full life", or well-lived life, is one that includes these three domains (Seligman et al., 2006). Recently, Seligman (2011) proposed the PERMA model which includes the following measurable elements: positive emotion, engagement, relationships, meaning and purpose, and accomplishment. According to Seligman et al. (2006), increasing positive emotion, engagement, and meaning could create a buffer against depression and possibly other disorders.

Positive Interventions and Tools

Positive interventions refer to systematic approaches that use clients' strengths and assets to overcome challenges (Rashid, 2009). They are based on three assumptions (Rashid & Seligman, 2013): first, clients desire growth and happiness, not only the avoiding of anxiety and misery; second, positive resources are genuine assets, not merely psychological defense mechanisms; and third, an effective therapeutic relationship includes discussion and focus on positive resources, not only an analysis of deficits and weaknesses. Rashid (2009) points out that positive interventions complement the clinical work.

A series of tools including interviews, inventories, scales, and narrative strategies are used to assess strengths-based constructs. Rashid and Ostermann (2009) outline the steps for conducting strengths-based assessment. The Values In Action Inventory of Strengths (VIA-IS; Peterson & Seligman, 2004) is a widely used, psychometrically sound 240-item self-report questionnaire for adults. It assesses 24 character strengths in about 25 min. For the assessment of strengths use, the 14-item Strengths Use Scale (Govindji & Linley, 2007) has been found to be a reliable and valid instrument (Wood, Linely, Maltby, Kashdan, & Hurling, 2011). Strengths use increases positive affect and is a good longitudinal predictor of well-being (Wood et al., 2011).

Positive interventions have been tested on individuals with depression. Positive psychotherapy (Seligman et al., 2006) and well-being therapy (Fava & Ruini, 2003) have shown good results (Sin & Lyubomirsky, 2009). Positive psychotherapy broadens the scope of traditional psychotherapy by integrating positive resources in treating psychopathology (Rashid & Seligman, 2013). It suggests that building positive emotions, engagement, and meaning could alleviate depression, and help buffer against the reoccurrence of negative symptoms (Seligman et al., 2006). Positive psychotherapy was used both in group and individual formats, with small samples of students (Seligman et al., 2006). In the group format, exercises such as *using strengths*, *writing three good things*, and *gratitude visits* were tested with cases of mild to moderate depression. Results showed a significant decrease in symptoms through 1 year follow-up (Seligman et al., 2006). In the individual format, focus was put on both positive and negative symptoms (positive psychotherapy was a supplement to other treatment approaches). A 14-session outline including exercises related to *signature strengths*, *gratitude*, *forgiveness*, *optimism*, *hope*, and *meaning* was tested with a small sample of severely depressed students. Results showed higher remission rates compared to traditional treatments (Seligman et al., 2006). Although more research is necessary with larger samples, these results suggest that positive psychotherapy may be a useful supplement to depression treatment protocols (Seligman et al., 2006).

Another useful approach for the treatment of depression is well-being therapy, developed by Fava and Ruini (2003). It is a short-term strategy rooted in positive psychology constructs that extends over eight sessions, and is based on Ryff's (1989) model of psychological well-being (Ruini & Fava, 2004). Well-being therapy aims at reinforcing beliefs that promote well-being by emphasizing self-monitoring of well-being episodes, and improving six dimensions of psychological well being: autonomy, personal growth, environmental mastery, purpose in life, positive relations, and self-acceptance (Fava & Ruini, 2003). Ruini and Fava (2004) reported a study with a small sample of 20 patients with affective disorders (including major depression) where well-being therapy led to both a greater reduction of residual symptoms and a greater increase in psychological well-being, in comparison with cognitive-behavior therapy. Another study with a sample of 40 patients with recurrent major depression showed that when well-being therapy was an adjunct to cognitive-behavior therapy, the relapse rate was significantly lower (Ruini & Fava, 2004). Although more research is necessary with larger samples, these results suggest that well-being therapy has the potential to be a good complement to cognitive-behavior therapy for the treatment of depression.

In terms of research, a meta-analysis of 51 positive psychology interventions showed that they significantly enhance well-being and decrease depressive symptoms (Sin & Lyubomirsky, 2009). Results revealed that individual therapy offered over a relatively long period of time, using a variety of positive exercises with emphasis on regular practice, is the most effective format. Sin, Della Porta, and Lyubomirsky (2011) pointed out that most positive interventions have been tested with non-clinical samples and do not necessarily benefit individuals in clinical contexts. Their study shows that, for example, writing letters of gratitude (a well documented

positive exercise) was counterproductive for dysphoric individuals and diminished their well-being. They recommended tailoring positive interventions to the resources, needs, and preferences of individuals presenting with depressive symptoms (Sin et al., 2011).

Therapeutic Process

In the framework of positive psychotherapy, a positive relationship is built with clients by encouraging them to describe themselves through a real life situation that shows them at their best. The VIA-IS is used to help clients identify their signature strengths. Then, through collaboration, the therapist and client design new ways of using client strengths in relevant areas such as work, friendship, love, etc. (Seligman et al., 2006). The goal of several positive psychotherapy exercises is to reorient capacities such as attention, memory, or expectations away from the negative and toward the positive (Seligman et al., 2006). The following factors could moderate the efficacy of positive interventions (Sin et al., 2011): therapeutic guidance, length of intervention and continued practice, outcome expectations, person-activity fit, social support, and depression status. Sin and Lyubomirsky (2009) recommended that practitioners assign multiple positive activities, take into account clients' cultural background and unique inclinations, and encourage continuous practice to turn learned strategies into healthy habits.

Positive psychotherapy is presented as a descriptive approach based on scientific evidence. It is not a one-size-fits-all approach and is not appropriate for all clients in all situations, like any other approach. Outcome studies are necessary for generalizability.

Meaning in Positive Psychology

The meaningful life consists of using one's signature strengths and talents in service of something bigger than the self, such as family, community, religion, politics, etc. (Seligman et al., 2006). Seligman et al. (2006) described studies with depressed patients that show that the pursuit of meaning and engagement is strongly correlated with less depression and greater life satisfaction, whereas the pursuit of happiness is marginally correlated with less depression and greater life satisfaction. They suggested that lack of meaning could be a cause of depression, and interventions that build meaning would relieve depression (Seligman et al., 2006).

A primary instrument used to measure meaning is the Meaning in Life Questionnaire (MLQ; Steger, Frazier, Oishi, & Kaler, 2006). The MLQ is a valid and reliable 10-item, two-subscale instrument that measures presence of meaning and search for meaning in life. *Presence of meaning* evaluates the degree of per-

ceived meaning and *search for meaning* assesses the extent to which a person engages in search for meaning (Steger et al., 2006). Meaning is defined as "the sense made of, and significance felt regarding, the nature of one's being and existence" (Steger et al., 2006, p. 81). The MLQ has been used in many different cultural contexts (O'Donnell, Shim, Barenz, & Steger, 2014).

In a review of the MLQ, O'Donnell et al. (2014) reported that presence of meaning is positively correlated with psychological well-being, hope, optimism and life satisfaction, and negatively correlated with anxiety, depression, and posttraumatic stress. The MLQ also has utility with individuals presenting with serious mental illnesses such as major depressive disorder, bipolar disorder, and schizophrenia (Schulenberg, Strack, & Buchanan, 2011). O'Donnell, Shim, Barenz, and Steger (2015) also highlighted the utility of the MLQ for individual therapy and recommended it for interventions in logotherapy, a meaning-centered approach to psychotherapy.

Happiness and Meaningfulness

A recent empirical investigation with a sample of 397 adults identified some differences between a happy life and a meaningful life (Baumeister, Vohs, Aaker, & Garbinsky, 2013). Results showed that although happiness and meaningfulness are positively correlated, and that many factors such as feeling productive or connection to others contribute similarly to both, they are distinct and sometimes even at odds with each other. Their findings suggested that happiness is mostly about feeling good in the present and about satisfying one's wants and needs, whereas meaningfulness involves integrating past, present, and future, focusing on expressing and reflecting on the self, and, in particular, reaching beyond oneself to do positive things for others. Baumeister et al. (2013) pointed out that these results are consistent with the hypothesis that happiness tends to be natural and self-focused, whereas meaning is mostly cultural and outwardly focused. They highlighted meaning as a key element that makes us uniquely human, and argued that not all people seek happiness. They referred to the downsides of the pursuit of happiness and the benefits that may arise from negative feelings. They recommended that positive psychology focus on researching and understanding meaningfulness and its differences with happiness (Baumeister et al., 2013).

Wong (2014) also shared interesting reflections regarding the concept of meaning in positive psychology. He noted that although meaning is an important component of positive psychology, its use in the framework of happiness orientation prevents the understanding that the pursuit of meaning could actually be at odds with the pursuit of happiness, because there is a contradiction: in order to serve a higher cause, one needs to transcend self-interest (Wong, 2014). Wong asserted that the view of meaning within the model of positive psychology is limited and prevents the full understanding of the value of meaning in human issues. He criticized the

almost exclusive cognitive focus of most current meaning-making models in making sense of the world in negative situations, and emphasized the need for a comprehensive and coherent theoretical framework to apprehend meaning in positive psychology. He proposed to advance both research and applications by better understanding meaning seeking based on Viktor Frankl's theory of search for meaning, that is, logotherapy (Wong, 2014).

Overview of Logotherapy

Logotherapy was pioneered by the Austrian neurologist and psychiatrist Viktor Frankl (1905–1997) during the 1930s. The Viktor Frankl Institute of Vienna defines logotherapy as "an internationally acknowledged and empirically based meaning-centered approach to psychotherapy" (Batthyany, n.d., Viktorfrankl.org). Frankl (1969) viewed logotherapy as an open, collaborative approach that could be combined with other psychotherapeutic orientations.

Fundamental Tenets

Logotherapy envisions the human person in three overlapping dimensions: somatic, psychological, and spiritual. Frankl (1969) referred to the spiritual dimension as "noetic" to avoid religious connotations. The noetic dimension is the site of authentically human phenomena such as self-distancing, self-transcendence, humor, love, and gratitude. 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 that makes human beings unpredictable. 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. The fundamental tenets of logotherapy are freedom of will, will to meaning, and meaning in life (Frankl, 1969). *Freedom of will* asserts that human beings have the freedom to choose their response within the limits of given possibilities, under all life circumstances. *Will to meaning* points out that the main motivation of human beings is to search for the meaning and purpose in their lives. *Meaning in life* highlights that life has meaning under all circumstances, even in unavoidable suffering and misery. Other important concepts in logotherapy are responsibility, healthy core, and tragic optimism (Frankl, 1959/1984). *Responsibility* is considered as the essence of human existence, reflecting our actions and behaviors to life challenges. *Healthy core* refers to the part that remains intact in spite of illness. *Tragic optimism* implies remaining optimistic through hope, faith, and love in spite of the inevitable tragic triad of pain, guilt, and death, in order to raise above suffering and turn the negative into positive or tragedy into personal triumph.

Therapeutic Process

The goal of the logotherapist is to tap into unique human capacities such as intentionality, responsibility, and freedom of choice, and to broaden clients' visual scope to help them discover and actualize the meaning potentials in their lives. The two primary, healthy resources accessed by the main logotherapeutic techniques are self-distancing (the ability to detach from one's self and differentiate between one's self and one's symptoms) and self-transcendence (the ability to live for something greater than the self). Martínez and Flórez (2014) described the phases of the meaning-centered therapeutic process and highlighted the clients' capacity to accept discomfort and to use healthy, existential resources as a key factor in producing change.

The three main techniques used in logotherapy are paradoxical intention (using self-distancing through humor to counteract anticipatory anxiety), dereflection (shifting the focus of attention toward meaning through self-transcendence), and attitude modification (challenging a negative attitude by activating the will to meaning through Socratic dialogue). Paradoxical intention, validated empirically for sleep disorders, agoraphobia, and public speaking anxiety (Schulenberg, 2003), has similarities with exposure techniques and anticipates some of the behavioral techniques such as implosion and satiation (Frankl, 2004). Dereflection is an important part of Frankl's sexual model proposed in 1947 that predates Masters and Johnson's sexual therapy model, developed in 1970 (Ameli & Dattilio, 2013; Schulenberg, Nassif, Hutzell, & Rogina, 2008).

Lukas (1998) pointed out that modifying an internal attitude leads to behavioral change and outlined the steps for "meaning sensitization" for cases of existential vacuum and a guideline for cases involving unavoidable suffering. Martínez and Flórez (2014) provided specific examples of how Socratic dialogue could be implemented to mobilize clients' spiritual resources. Another interesting tool is the *Values Awareness Technique* (VAT) developed by Hutzell and Eggert (1989/2009), where the goal is to help people discover their personally meaningful values hierarchy (based on Frankl's categorical values), as well as to define meaningful goals for the short, intermediate, and long term, aligning them with their values. Recently, Rogina (2015) proposed a seven-step *noogenic activation* clinical process to mobilize the noetic dimension and tap into clients' healthy core in order to facilitate meaningful change.

Meaning in Logotherapy

Meaning is based on self-transcendence, on transcending self-interest and reaching beyond one's self to serve a cause or others. According to Frankl (1959/1984), in contrast with Maslow's concept of self-actualization, happiness cannot be pursued nor is it the end goal; it is a by-product of self-transcendence. Lukas (2015)

pointed out that the discovery of a meaning to be fulfilled is key to an individual's psychological health.

Meaning in logotherapy is inherent to the noetic dimension, to what makes us human. It cannot be invented; it needs to be discovered in the world (Frankl, 1959/1984). There are various levels of meaning (Fabry, 1994; Lukas, 2015). *Ultimate meaning* presupposes the existence of a universal order that cannot be comprehended from a rational perspective. *Meaning contents of one's life* (Lukas, 2015) refers to *being for something* (a task, a mission, a work, etc.) or *being for someone* (caring for family, children, etc.). The *meaning of the moment* may be recognized and responded to by each unique individual in a unique situation. We can discover meaning in life in three different ways known as the categorical values. These categorical values are comprised of the *creative values*, the *experiential values*, and the *attitudinal values* (Frankl, 1959/1984). The creative values consist of what we give to the world, like accomplishing a task, creating a work, or doing a good deed. The experiential values are 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 values reflect the stand we take toward an unchangeable situation or unavoidable suffering. When the will to meaning is frustrated or blocked and a person is incapable of finding a meaning or purpose in his/her life, there is a perception of emptiness, hopelessness, or despair that Frankl (1969) called *existential vacuum*. Some of the symptoms of this condition include apathy and boredom, and it may lead to aggression, addiction, and depression. Frankl (2004) defined *noogenic neurosis* as a clinical condition where the psychological symptoms are a result of existential conflicts. He proposed logotherapy as the specific therapy for the treatment of existential problems. Logotherapy is offered as a nonspecific or collaborative therapy for other types of issues.

"Search for meaning" has been included in the newest *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (*DSM-5*; American Psychiatric Association, 2013) among the features of a "normal" personality (Marshall, 2014). In clinical practice, logotherapy has been found to be useful with problems such as depression, anxiety, alcohol/drug addiction, and despair associated with incurable disease (Schulenberg et al., 2008). Schulenberg, Drescher, and Baczwaski (2014) also highlighted the potential value of logotherapy in coping with adversity and promoting posttraumatic growth in the framework of disaster mental health.

In terms of research, a large number of studies have been conducted to validate the main logotherapeutic concepts and tools (Batthyany & Guttmann, 2006). The most investigated psychometric tool to assess meaning is the Purpose in Life test (PIL), developed by Crumbaugh and Maholick in 1964. It measures the degree to which a person experiences a sense of personal meaning. PIL scores correlate positively with measures of self-control, life satisfaction, self-acceptance, emotional stability, and resilience, and they are correlated negatively with anxiety and depression (Melton & Schulenberg, 2008). The Purpose in Life test-Short Form (PIL-SF; Schulenberg & Melton, 2010; Schulenberg, Strack, et al., 2011) is a brief four-item version of the PIL. The PIL-SF is a valid and reliable instrument that offers unique

psychometric contributions beyond other meaning assessment tools (Schulenberg, Strack, et al., 2011). It has been used as a measure of perceived meaning with both clinical and non-clinical samples in various research areas, such as alcohol use, resilience, and disaster mental health. Results show a strong relationship between perceived meaning and alcohol use among college students, and an interaction between meaning and depression in predicting alcohol use in males (Schnetzer, Schulenberg, & Buchanan, 2013). In the framework of a technological/ecological disaster, perceived meaning in life was shown to be predictive of life satisfaction after the spill, and may actually be a stronger predictor than self-efficacy in some cases (Drescher et al., 2012).

The 14-item Resilience Scale (RS-14; Wagnild, 2009) is another interesting instrument that correlates with perceived meaning in life and shows substantial overlap with PIL-SF, correlating at 0.67–0.69 and sharing 45–48 % of the variance (Aiena, Baczwaski, Schulenberg, & Buchanan, 2015).

Research supports logotherapy's assertion that meaning is crucial to the human experience (O'Donnell et al., 2015). The need for increasingly rigorous research is emphasized to validate the logotherapeutic model across diverse populations and disorders (Martínez & Flórez, 2014; Melton & Schulenberg, 2008) and test it against empirically robust therapeutic models (Martínez & Flórez, 2014).

Areas of Similarities and Differences Between the Three Approaches

Cognitive-Behavior Therapy and Positive Psychology: Similarities and Differences

Cognitive-behavior therapy and positive psychology are empirically based and rely on rigorous scientific research. They both favor a "natural" self, motivated toward satisfying wants and needs (Baumeister et al., 2013; Wong, 2014). They share areas of similarities such as an emphasis on therapeutic alliance, a focus on discrete goals and present issues, and a collaborative approach (Karwoski, Garrat, & Llardi, 2006). Several cognitive-behavioral techniques such as pleasant activities scheduling, relaxation techniques, and problem solving may also be used in positive psychology interventions (Karwoski et al., 2006). The main difference between both approaches is their focus. Cognitive-behavior therapy aims primarily to overcome disorders and reduce distress and positive psychology focuses on increasing well-being using a strengths-based approach.

The two approaches seem compatible and complementary and their integration has been proposed in several models such as well-being therapy (Fava & Ruini, 2003), the integrative model for depression (Karwoski et al., 2006), and positive CBT (Bannink, 2012). Cognitive-behavior therapy and positive psychology have also developed resilience models, drawing on research in both fields. Ann Masten,

one of the pioneers in the study of resilience, defined it as "a class of phenomena characterized by good outcomes in spite of serious threats to adaptation of development" (Masten, 2001, p. 228). Resilience is a process, and Yates and Masten (2004) highlighted the importance of applying positive psychology in resilience interventions in order to promote prevention and competence in addition to symptom alleviation. Tugade and Fredrickson (2004) reported various studies that confirm the broaden-and-build theory (Fredrickson, 2001) that takes into account the adaptive function of both positive and negative emotions, and according to which resilient individuals use positive emotions to cope and bounce back from negative experiences. Reivich and Shatté (2002) offered a seven-step program, based mostly on cognitive-behavior strategies, to build resilience. Padesky and Mooney (2012) proposed a four-step cognitive-behavior therapy model to build and strengthen resilience.

Positive interventions and tools seem to be a good adjunct to broaden the scope of cognitive-behavior therapy beyond treatment, toward well-being and resilience.

Logotherapy and Cognitive-Behavior Therapy: Similarities and Differences

Logotherapy has anticipated some of the concepts of cognitive-behavior therapy. The two approaches present many similarities and a high degree of compatibility (Ameli, 2016; Ameli & Dattilio, 2013). They both emphasize that modifying internal maladaptive attitudes leads to behavioral change, their main goal is to resolve present issues, and a caring and warm therapeutic alliance is emphasized. Both approaches are active, participative, and collaborative, using a process of guided discovery without the therapist imposing his/her personal concepts of reason or meaning. In terms of techniques, both approaches are sound, brief, solution-focused and take into account empirical research.

There are also major differences between cognitive-behavior therapy and logotherapy (Ameli, 2016). Logotherapy goes beyond learning principles, reinforcement, rationality and cognition, taking into account the uniquely human noetic dimension. The primary focus of logotherapy is to discover life meaning and purpose versus modifying erroneous thinking patterns and reducing distress in cognitive-behavior therapy. Logotherapy is values-based, mobilizing clients' healthy resources, strengths, and aims to facilitate well-being. Martínez et al. (2015) pointed out that the vision of the human person according to cognitive-behavior therapy tends to be deterministic and reactive whereas logotherapy emphasizes a proactive and intentional view.

The integration of logotherapy with cognitive-behavior therapy has been proposed by several authors such as Lukas (1986), Hutchinson and Chapman (2005), Hutzell (2009), and Ameli and Dattilio (2013). For a summary of these proposals see Ameli (2016). Recently, Marshall (2014) proposed to incorporate *freedom of will* for the diagnosis and treatment of personality disorders and recommended

combining cognitive-behavior therapy with logotherapy to help clients in the process of search for meaning. Lukas (1986) envisioned a "fruitful symbiosis" between cognitive-behavior therapy and logotherapy, and considered that their future depends on the motivation of their respective representatives to combine them.

Logotherapy and Positive Psychology: Similarities and Differences

Logotherapy and positive psychology have much in common. They are both future-oriented and strengths-focused, they both consider meaning as an important element of well-being, and they have both garnered psychometric support through meaning-based assessment (Lewis, 2012; Schulenberg et al., 2008; Wong, 2014). Both approaches consider the lack of perceived meaning as a potential cause of depression and propose meaning-based interventions as a means of alleviating symptoms of depression. In terms of their foundation, Lewis (2012) pointed out that the concept of experiential values is similar to the pleasant life and the concept of creative values is similar to the engaged life. In positive psychology, a full life is the one that enriches and integrates these three types of life (pleasant, engaged, and meaningful), and in logotherapy a meaningful life is one where the three types of values (experiential, creative, and attitudinal) are actualized to the highest degree. What Seligman calls "strengths", Frankl calls "values" and both orientations use instruments to identify strengths or values: the Values Awareness Technique (VAT; Hutzell & Eggert, 1989/2009) is used in logotherapy, and the Values In Action Scale (VIA-IS; Peterson & Seligman, 2004) in positive psychology.

There are also major differences between logotherapy and positive psychology. According to Lewis (2012), logotherapy is a form of therapy developed through clinical practice that insists on a genuine human dimension, in contrast with positive psychology which was developed through empirical studies. Wong (2011, 2014) pointed out that logotherapy promotes a spiritual-existential perspective ("spiritual self") while positive psychology prioritizes a cognitive-behavioral perspective ("natural self"). Self-transcendence is the essence of being fully human in logotherapy, the main motivation and an end in itself, whereas happiness and well-being tend to be the end goal in positive psychology and self-transcendence an instrument to reach well-being. In logotherapy, meaning seeking is spiritual and aimed toward self-transcendence, whereas meaning seeking in positive psychology involves a cognitive process to facilitate understanding and life purpose (Wong, 2014).

The integration of positive psychology with logotherapy and the existential approach in general has also been considered (Batthyany & Russo-Netzer, 2014). Schulenberg et al. (2008) suggested incorporating the clinical work done in logotherapy into positive psychology, since what each brings to the table can inform one another. Bretherton and Ørner (2004) focused on the positive aspects of the existential approach, referring to concepts such as meaning, posttraumatic growth, and concern for society. They recommended the inclusion of existential concepts in further

development of positive psychology. Wong (2014) suggested further exploring and understanding the concept of meaning and search for meaning within the framework of logotherapy, in order to arrive at a coherent and comprehensive theoretical framework for meaning in positive psychology. He asserted that positive psychology could benefit from Frankl's deep insights and theory of meaning, and that logotherapy could benefit from positive psychology's rigorous meaning-related research. According to Wong, the integration of the spiritual dimension toward self-transcendence and a "spiritually oriented positive psychology" could be beneficial to the positive movement (Wong, 2014).

Wong (2009, 2011) made a compelling case for an existential positive psychology that broadens the scope of positive psychology and integrates the whole spectrum of human experiences, both positives and negatives, both challenges and potentials. He proposed *positive psychology 2.0* as a more complete model of the good life, where a *meaning mindset* (that embraces also negativity) is promoted versus the *happiness mindset* (Wong, 2011). Following Wong's ideas and other critics regarding the excessive positive polarization and focus on the bright side, a *second wave positive psychology* has emerged (Ivtzan, Lomas, Hefferon, & Worth, 2015; Lomas & Ivtzan, 2015). This second wave proposes a more nuanced approach to the concepts of positive and negative, focusing on the dialectical nature of well-being. Lomas and Ivtzan (2015) identified the three key components of the dialectical nature as the principal of appraisal (challenge with categorizing phenomena as positive or negative), the principal of co-valence (experiences are a mix of positive and negative factors), and the principal of complementarity (well-being is a function of a complex interaction between bright and dark aspects). They provide several case studies to illustrate these principles (Lomas & Ivtzan, 2015). Along the same lines, Kashdan and Biswas-Diener (2014) proposed the concept of *wholeness*, instead of happiness, as a healthy living state. Wholeness is an emotional state that includes both positive and negative emotions. According to these authors, unpleasant emotions should be acknowledged and experienced because tolerating psychological discomfort could help people become stronger, happier, and more resilient in the long term (Kashdan & Biswas-Diener, 2014).

The influence of existential concepts in second wave positive psychology makes it closer and more compatible with logotherapy. Wong (2014) recommended future research to integrate logotherapy and positive psychology for the benefit of both psychology and society.

Logotherapy as a Bridge Between Cognitive-Behavior Therapy and Positive Psychology

Logotherapy is compatible and complementary to both cognitive-behavior therapy and positive psychology. Its tri-dimensional view of human beings and will to meaning framework broadens the scope of both approaches, making cognitive-behavior therapy sensitive to freedom of choice and existential meaning, and

positive psychology sensitive to self-transcendence and the dark side of life, emphasized also in second wave positive psychology. It appears to be a potent and enriching bridge between these two orientations at the clinical level.

Toward an Integrative Model of Clinical Intervention: Cognitive-Behavior Therapy, Logotherapy and Positive Psychology

The generic cognitive model (Beck & Haigh, 2014) is empirically based and could serve as an expandable template for integration. At the theoretical level, logotherapy could be included at two levels: (1) intentionality based on freedom of choice could be a feature within the reflective system; and (2) meaning could be added on a second continuum, similar to the adaptive function. The meaning continuum would move from meaningful to meaningless. The interesting feature about the continuum is that it takes into account the degree of adaptability and meaningfulness instead of categorizing in terms of positive and negative. Resilience, based on concepts and research drawn from the three approaches, could be considered a feature within the self-expansive mode.

At the clinical level, two more components could be included (in addition to situation, biased belief, focus, and maladaptive behavior), *meaningfulness* based on logotherapy's theoretical framework and *resilience*. Interventions for meaning assessment and discovery would include logotherapy techniques and tools as well as positive psychology's strategies. Instruments such as the PIL-SF (Schulenberg, Schnetzer, & Buchanan, 2011), the MLQ (Steger et al., 2006), and the VAT (Hutzell & Eggert, 1989/2009) have demonstrated utility. The concept of meaning could also be integrated within each separate intervention area (situation, belief, focus, and behavior). Meaning related to a specific situation could be considered. The degree of meaningfulness of beliefs could be assessed, in order to promote both realistic and meaningful beliefs. In the focus category, the dereflection technique could be added as an attentional strategy to refocus on meaningful areas. In the behavior category, intentional meaningful behaviors and actions could be promoted. As for resilience, it could be considered at two levels. It could be assessed at the beginning of therapy, using for example the 14-item Resilience Scale (RS-14; Wagnild, 2009), along with the possession and use of strengths by measures such as the VIA-IS (Peterson & Seligman, 2004) and the Strength Use Scale (Govindji & Linley, 2007). Such data could be helpful in better tailoring therapy to the client because individual strengths and potentials would be taken into account as part of the case conceptualization. Resilience could also be included as part of a relapse prevention strategy. Moreover, logotherapeutic and positive interventions could be implemented to create a meaningful life and build resilience.

As part of the therapeutic process, although many clients seeking help might use the word happiness as their goal, it would be unwise for the therapist to assume that they all have the same definition or the same objective. An astute therapist would

first seek to understand the client's definition and then as part of psychoeducation, provide definitions and information based on research regarding both the concepts of happiness and meaningfulness, including their upsides and downsides. As the person responsible for his/her life, the client could choose his/her preference, assuming both positive and negative consequences in the short and long term. Happiness should not be the exclusive pursuit of the client, nor imposed on clients through the therapist's assumption that everybody wants to be happy. As therapists, we also have the responsibility to support those clients who consider themselves not very happy, to move forward in spite of difficulties and challenges. Examples include clients experiencing chronic or serious illness or those who have meaningful tasks that require self-sacrifice, such as single parents working and raising children without a support system. Logotherapy and its concept of meaning based on self-transcendence would potentially be a useful adjunct in such cases. For clients with severe disorders such as schizophrenia, logotherapy could help tap into healthy areas, assisting clients in discovering meaning in spite of suffering.

For a more balanced therapeutic approach, it would be interesting to use concepts from second wave positive psychology such as *wholeness* (Kashdan & Biswas-Diener, 2014), and considering well-being as the interaction between negative and positive emotions (Ivtzan et al., 2015; Lomas & Ivtzan, 2015; Wong, 2011).

Example of an Integrative Clinical Model for Depression

The three approaches offer treatment guidelines and tools for the treatment of depression. Cognitive-behavior therapy has an empirically supported and well-established protocol to reduce distress. Positive psychology has developed a strengths-based outline to directly increase positive emotions, character strengths, and meaning. Logotherapy is a specific meaning-centered therapy for cases of depression related to a sense of meaninglessness, and is also a good adjunct for treating depression associated with other factors. Steps for *meaning sensitization* have been outlined by Lukas (1998), with cases illustrated in her writings (Lukas, 1986, 2014, 2015). Moreover, Martínez (2013) developed *training in meaning perception*, Ungar (2002) illustrated a logotherapeutic treatment protocol in a case of somatogenic, endogenous depression, and Ameli and Dattilio (2013) offered ideas of how to integrate logotherapy with Beck's depression protocol.

The following steps are proposed as a general guideline for an integrative model of depression, considering input from the three approaches:

1. Broad case conceptualization: relevant instruments from cognitive-behavior therapy, logotherapy and positive psychology are used to assess the type and severity of depression, and highlight both client areas of weakness and strengths in the intervention areas of the generic cognitive model, including meaningfulness and resilience. The goal would be to develop a map of strengths and weaknesses, problems, and potentials.

2. Creation of an optimal, individualized treatment plan: clarify the areas of strengths and limitations and, based on the client's characteristics, identify the relevant techniques and strategies from the three approaches in order to motivate the client, draw on his/her strengths throughout the treatment process, help him/her to overcome weaknesses, and build meaning and resilience. Emphasis is placed on establishing a warm and genuine therapeutic relationship and prioritizing the client's unique attributes within the tri-dimensional view (biological, psychological, and noetic).
3. Explanation of hypotheses, the treatment plan, and goal setting: provide a coherent and clear explanation of the problematic symptoms based on the client's individual map and set therapeutic goals collaboratively. One idea would be to explain that therapy has three objectives:

   (a) Help the client detect maladaptive beliefs and behaviors that are working to maintain depression. Assist the client in learning how to turn them into more reasonable and adaptive ones. The main objective would be to address what is not working in order to minimize distress, through primarily cognitive-behavioral techniques.
   (b) Help the client identify and refocus attention on unique strengths, values and positive opportunities and use them to convert reasonable thoughts into meaningful, motivating, and proactive decisions, actions, and attitudes. The goal would be to use the concept of meaning in order to tap into potentials as a means of enhancing well-being, using strategies from logotherapy and positive psychology.
   (c) Help the client build resilience and create a meaningful life plan, inviting him/her to reflect and learn from the experience of depression, which is possible in spite of any suffering experienced. Clients are encouraged to practice their strengths, and increase positive emotions, engagement, and meaning. Research and tools from the three approaches would be beneficial in this stage.

4. Psychoeducation: provide a brief and clear explanation of the three approaches as well as their relevant techniques and goals. Explain the differences between happiness and meaningfulness based on research findings, and introduce concepts such as wholeness (Kashdan & Biswas-Diener, 2014) and the dialectical nature of well-being (Lomas & Ivtzan, 2015; Wong, 2011) from second wave positive psychology.
5. Integrative treatment plan (see Ameli & Dattilio, 2013): combine pleasurable and meaningful activities based on client values (creative, experiential, and attitudinal). Moreover, combine cognitive restructuring with attitude modification to generate both adaptive and meaningful thoughts and beliefs, and use dereflection as a refocusing strategy to counteract rumination. For severe depression associated with suicide, finding meaning could be a key first step (prior to cognitive behavioral interventions), to help clients shift their attitude and hold on to life (Ameli & Dattilio, 2013). Also, as proposed by Karwoski et al. (2006), cultivating hope is helpful to motivate clients and reduce depressive symptoms.

6. Relapse prevention: reflection through Socratic dialogue regarding the possible meaning of the depression within the client's life, what he/she has learned from depression in spite of any suffering experienced, and the attitude he/she can choose to prevent the onset of another depression. In addition, emphasis is placed on the design of a meaningful and purposeful life plan (the VAT could be valuable), as well as a training program geared toward building well-being and resilience using a variety of relevant positive psychology tools and exercises. Examples include practicing strengths in different situations, or gratitude exercises, taking into account the cultural background, needs and preferences of the client. Emphasis should be placed on regular and continuous practice of the skills learned in therapy, especially the positive exercises, in order to turn them into adaptive habits.

Conclusion

Logotherapy is a collaborative, meaning-centered, and empirically supported approach to psychotherapy with broad clinical applications. It emphasizes the unique human dimension. It shares multiple similarities with both cognitive-behavior therapy and positive psychology, fitting well with both orientations. These approaches complement and would also benefit from one another.

Logotherapy offers a coherent and sound theoretical framework for understanding meaning that goes beyond rationality and positive emotions. Meaning is essentially a bridge between cognitive-behavior therapy and positive psychology. It broadens the scope of cognitive-behavior therapy beyond rationality, enriching positive psychology's framework through self-transcendence and an emphasis on meaning associated with negative experiences, challenges, and struggles as potential sources of growth and resilience. Bridging reason and resilience through meaning facilitates the shift from a natural and rational self to a self-transcending and meaning-oriented self. The recent second wave positive psychology movement (Ivtzan et al., 2015; Lomas & Ivtzan, 2015; Wong, 2011) offers a more balanced view that includes both bright and dark aspects of emotion, considering negative experiences and emotions as opportunities for positive transformation. Positive and negative features are context sensitive and could be viewed on a continuum. They are both valuable in clinical practice. For instance, in many cases negative emotions are a good source of learning.

In this chapter, ideas are offered for integrating cognitive-behavior therapy, logotherapy, and positive psychology using Beck's new generic cognitive model as a template. It would be interesting to establish collaboration between experts in the three fields, in order to review, refine, and test the ideas proposed, and validate a model that would include the best of reason, meaning, and resilience (a reasonable, meaningful, and potent guide for treating depression). Integrating cognitive-behavior therapy, logotherapy, and positive psychology would lead to a more balanced, holistic, and unified psychotherapy, with a broad view of human beings,

where both opportunities and challenges are taken into account and meaning potentials are emphasized across situations.

Over the past few years, spiritually-based practices such as mindfulness, rooted in Buddhism, and other concepts such as compassion, acceptance, and loving-kindness have been included in scientific protocols as part of third-wave behavior therapies. It seems that science is looking for wisdom to enhance psychological treatments. That wisdom is an inherent part of logotherapy, a psychotherapy that includes the noetic spiritual dimension, promoting meaning as a unique human feature. Therefore, it would be useful to take into account the wealth of knowledge that logotherapy offers in order to expand our understanding of the clinical applications of meaning.

Key Takeaways

- Adopt a tri-dimensional view of clients (bio-psycho-noetic) and identify what makes them unique, their specific strengths and potential.
- Take time to build a genuine, caring, and warm therapeutic relationship.
- Be open to an integrative approach, consider both negative and positive emotions, and include interventions focused on both reducing distress and increasing well-being.
- Become familiar with assessment tools and techniques used in cognitive-behavior therapy, logotherapy and positive psychology, and implement them in the different stages of depression treatment, considering clients' unique characteristics and needs.
- Cultivate a curiosity about the concept of meaning, include it in the cognitive-behavior therapy depression protocol and explain its benefits to clients.
- Draw on clients' strengths and values throughout therapy and tailor positive psychology interventions emphasizing regular practice. Consider also implementing concepts from second wave positive psychology.

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