

Enhancing Cognitive Behavior Therapy With Logotherapy: Techniques for Clinical Practice

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Logotherapy is a meaning-centered approach to psychotherapy, which is compatible with cognitive behavior therapy. Its basic tenets have the potential to increase both the efficacy and effectiveness of the therapeutic process. This article describes the main techniques of logotherapy and provides specific and practical examples of how they may be incorporated into a cognitive behavior framework. The article concludes with a proposal for future research to validate integrative treatment protocols, and to provide an empirical base for logotherapy-enhanced cognitive behavior therapy.

Keywords: logotherapy, cognitive behavior therapy, paradoxical intention, meaning, integrative treatment protocols

Logotherapy is a documented form of Psychotherapy that has been in existence for over eight decades. On many levels, logotherapy presents a high degree of compatibility with cognitive behavior therapy, a popular more contemporary form of evidenced-based treatment. The objective of this article is to present the main techniques used in logotherapy and offer practical examples of how they may be integrated into Beck's model of cognitive behavior therapy to enhance the efficacy and effectiveness of the therapeutic delivery process. After a brief overview of logotherapy, the article focuses on the practical use of the techniques and concludes by presenting the potential advantages of a logotherapy-enhanced cognitive behavior therapy, along with suggestions for future research.

Overview of Logotherapy

Logotherapy was developed 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.” Frankl viewed logotherapy as an open system, a collaborative approach that could be combined with other psychotherapy orientations (Frankl, 2004). 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. It was also Frankl's belief that, “inherent in our responses to life lies the growth and freedom to choose” (V. E. Frankl, personal communication, March 29, 1980).

The fundamental tenets of logotherapy are outlined below as described by Frankl (1969):

Vision of man in three overlapping dimensions: somatic, psychological, and spiritual. The spiritual dimension is referred to as “noetic” and is considered the site of authentically human phenomenon such as love, humor, or gratitude and distinguishes human beings from other animals. Intentionality is the key factor with this concept and involves the understanding that we have a choice in the manner in which we behave. The concept of *freedom of will* underscores the notion that human beings are free to choose their responses within the limits of given possibilities, under all life circumstances. They are not “free from” their biological, psychological, or sociological conditions, but they are also not fully determined because they are “free to” take a stand toward those conditions. Frankl also spoke about *will to meaning*, which involves the primary motivation of human beings to search out the meaning and purpose of their lives. Meaning can surpass pleasure because human beings are capable of sacrificing pleasure and supporting pain for the sake of a meaningful cause. Hence, *meaning in life* involves meaning under all circumstances, even in unavoidable suffering and misery.

According to logotherapy, we can discover meaning in life in three different ways—through “creative values,” “experiential values,” and “attitudinal values” (Lewis, 2011). The *creative value* consists of what we give to the world, such as accomplishing a task, creating a work, or doing a good deed. The *experiential value* is what we take from the world, such as the experience of truth, beauty, and love toward another human being. The *attitudinal value* reflects the stand that we choose to take toward unchangeable situations or unavoidable suffering (Lewis, 2011).

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When the will to meaning is frustrated or blocked, logotherapists believe that one tends to experience a sensation of emptiness, hopelessness, or despair. This is a concept that Frankl referred to as an *existential vacuum* (Frankl, 1969). Some of the symptoms of that condition include apathy, boredom, and in some cases may lead to aggression, addiction, and depression.

Techniques and Interventions of Logotherapy

Paradoxical Intention

Description and theoretical base. The technique of paradoxical intention was first used by Frankl in 1929 and is based on the concept of self-distancing through the use of humor or, at times, absurdity. For example, a client may be asked to expose him/herself to his or her worst fear by wishing for (with humorous exaggeration) the very object that provokes the greatest fear or anxiety. In the case of a person who is experiencing panic attacks and fears suffering a heart attack, the client would be instructed to say to him/herself: "I look forward to having a dandy of a heart attack today, falling to the ground and making a spectacle of myself." Paradoxical intention counteracts anticipatory anxiety by having a reciprocal impact on the symptoms and thus breaking anxiety's vicious circle. It has been used with cases of anxiety and panic disorders (Dattilio, 1987, 1994), as well as with a host of other cases (Ascher, 1989; Ascher & Efran, 1978). It has also been used in some cases during the course of family therapy as well (Dattilio, 2010).

Frankl (2004) points out that there are many similarities between paradoxical intention and behavioral techniques such as exposure, flooding, or satiation. Ascher (1989) shares the opinion that some of the techniques developed in the frame of behavior therapy, mainly implosion and satiation, are simply "the translation of paradoxical intention."

Logotherapy posits the use of humor as the essence of paradoxical intention and what distinguishes it from behavior modification techniques (Frankl, 2004). Humor is a healthy human resource directed only toward the symptom, not the client.

In summary, paradoxical intention begins with self-distancing from one's symptom (through humor), which is followed by a change of attitude and symptom reduction (Lukas, 1981).

Clinical intervention. In the following excerpt, paradoxical intention is used with a woman who is struggling with perfectionism:¹

Client: I have a lot of anxiety at work. I am constantly preoccupied with making mistakes. I try to make sure that everything is perfect so that my boss and coworkers won't think that I am incompetent. What bothers me most is that I am bored and I don't even want to be in this job anymore, but I just can't stop worrying and pushing myself to be perfect.

Therapist (after explaining the technique of paradoxical intention): here is what I suggest that you tell yourself each morning before going to work: "I am going to win the award for the most incompetent and imperfect employee. I am going to show everyone at the office how incompetent I truly am so that they will fire me and free me at last from this boring job! I need some adventure in my life!"

On hearing the instructions, the client began laughing and was able to embrace the humor of making such a ridiculous statement.

She reported that by repeating the instructions on her way to work each day, she giggled, which helped to reduce her symptoms of anxiety and engage in less rumination. After a few days, she was able to commence work with less tension and take things much less seriously.

Research. The initial attempt to validate the technique of paradoxical intention within an experimental context was made by behavior therapists in the 1970s. Ascher and Efran (1978) report a study confirming that paradoxical intention is a clinically effective technique for cases of onset insomnia resistant to behavioral treatments.

A recent review of 19 clinical outcome studies involving paradoxical intention was conducted by Fabry (2010). 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). Paradoxical intention has been validated empirically for sleep disorders, agoraphobia, and public-speaking anxiety, especially in the presence of recurrent anxiety (Schulenberg, 2003).

In terms of clinical intervention, Dattilio (1987, 1994) also presented two panic disorder cases that were treated successfully by integrating behavioral techniques with paradoxical intention.

Dereflection

Description and theoretical base. Frankl developed the technique of dereflection in the early years following World War II. It is based on the concept of self-transcendence (reaching beyond oneself). In contrast with Maslow's concept of self-actualization, Frankl declares "being human always points, and is directed, to something, or someone, other than oneself—be it a meaning to fulfill oneself or another human being to encounter" (Frankl, V. E., 1959/1984). In this case, self-actualization is essentially a side effect of self-transcendence.

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 redirects it toward another person or a motivating/meaningful area (Frankl, 2004).

The dereflection technique was originally developed as a treatment with sexual disorders. Lukas (1998) describes the procedure as a two-step process: one—a "stop signal" is given to the client, to ignore the ruminative thoughts. The second step is a "deviation signal" designed to change the direction of one's outward thoughts and focus on meaning.

Lukas (1981) outlines the following four sequences for dereflection: (1) self-transcendence, (2) finding meaningful tasks and goals, (3) symptom reduction, and (4) change in attitude.

In the process of dereflection, to facilitate meaningful discovery, the "Values Awareness Technique" (VAT) could be used effectively. This technique, developed by Hutzell and Eggert (1989/1995/2009), involves a paper and pencil format. The main objective is to help people become aware of their personally meaningful values hierarchy (based on Frankl's categorical values), define

¹ Written consent and permission have been obtained from this client to use in this publication of case material.

meaningful goals, and align them with their values. It shows clients how to define precisely their purposeful goals for short, intermediate, and long-term use.

Clinical intervention. The dereflection technique could be integrated nicely within a cognitive behavior therapy protocol for depression at two levels. It may be effective with the *Scheduling activity technique* in which self-transcendence is used to generate activities that are not only pleasant but also meaningful considering the client's personal values (creative, experiential, and attitudinal). The therapist might ask the following questions: "who are you here for?," "what do the significant people in your life need from you at this moment?," "what is life asking of you at this time in spite of the apathy and sadness?," "looking back at your life, what are the most meaningful or significant moments you can remember?," "what were you doing at the time?," "what were your main tasks, activities, and goals?," "whom were you spending time with?," "which past activities that you engaged in were so absorbing that you forgot about time and everything else while performing them?," "in the past when dealing with difficult times, what gave you strength and courage to move on?."

At the end of therapy: the client's values could be used to direct him/her toward building a meaningful life that would increase his or her well-being. After using cognitive-behavior therapy techniques to correct dysfunctional thought patterns, the therapist guides the client to choose and implement meaningful goals, projects, and attitudes: "based on your personal values we explored earlier (creative, experiential, and attitudinal), what meaningful opportunities are available to you in different areas of your life?," "which are the most meaningful ones?," "what steps could you take to implement each of them? Write each step out and implement them into your daily activity," "which attitudes are you planning to choose in order to move forward with your goals and prevent another onset of depression?."

In this step, the VAT (Hutzell & Eggert, 1989/2009) could also be used to help the client define precisely his or her meaningful goals for both short- and long-term use.

Research. The dereflection technique is a crucial part of the sexual therapy model proposed by Frankl in 1947. His work predated Masters and Johnson's sex therapy model that was developed in 1970.

Ascher (1980) points out that although many components of the Masters and Johnson's sex therapy model were based on data derived from their own research, significant aspects of their therapeutic programs had previously appeared in the professional literature; among them "dereflection" and Wolpe's desensitization techniques. In his opinion, it does not seem unreasonable that these therapeutic components could be responsible for much of the clinical success reported by Masters and Johnson (Ascher, 1980).

Attitude Modification

Description and theoretical base. This term was coined in 1980 by a student of Frankl's, Elisabeth Lukas (Lukas, 1998). It is essentially a guided discovery process. Through the Socratic dialogue, the client explores personally meaningful values and available perspectives, options, attitudes, and actions.

Lukas (1998) points out that in contrast with behavior modification, logotherapy's focus is to first modify the attitude. According to logotherapy, modifying an internal attitude leads effortlessly

to a modified behavior. The objective of attitude modification is to help the client improve his or 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 his or her life). In the cases of unavoidable suffering, when faced with unchangeable and negative external factors, the client still has the choice to adopt a new attitude toward his/her situation (Lukas, 1998).

This technique could be used for issues such as guilt, loss, grief, suffering, serious diseases or terminal illnesses, neurosis, and depression. A good example of this is portrayed in a case example by Dattilio and Hanna (2012) in which the therapist used a combination of cognitive behavior therapy and logotherapy to help Dattilio's client, an emergency room physician's assistant, process a young male patient's untimely death.

Clinical intervention.

Case 1: The freedom of choice: In spite of the fear. The following dialogue illustrates the therapeutic approach used in a case of Generalized Anxiety Disorder.¹

Client: I just can't control this fear that my husband is going to have an accident when he travels and I have to call him each time he leaves the house. I've even begged him not to travel but he loves traveling and it's also an important part of his job. He is tired of my constant phone calls and tells me that I am selfish and that my fear is simply ridiculous.

Therapist: I understand that you can't always control when or how your fears appear. However, you are free to decide what do to when you become frightened. What options do you view yourself as having at your disposal?

Client: to call him all of the time, which only makes things worse, or just sit around I guess, paralyzed and worrying until he returns and not get anything done. Or, maybe just to go on with my day without thinking about it, but I really don't know if I can do that.

Therapist: how about choosing to move on with your daily tasks in spite of the fear? You see, you do have a choice! You can choose to behave as if you were a "slave" to your fear and let it immobilize you or decide to take a stand and become the "master" by telling yourself: I am going to focus on my daily tasks in spite of the fear and refuse to allow it to paralyze me. I am going to show my husband that I am able to face this fear because my love for him is stronger than fear itself. This is something he can be proud of.

Client: This is pretty tough to do but I will give it a try because I don't want to be a slave to my fear anymore. This is not the way I want to live my life!

Case 2: Discovering meaning in suffering. The following example related by Frankl (1959/1984, p. 135) shows the value of the concept of meaning in facilitating a quick attitudinal change. In a case of unavoidable suffering, an elderly physician with severe depression consulted Frankl. He had lost his wife two years prior and was struggling to overcome his grief:

Frankl: "What would have happened, Doctor, if you had died first, and your wife would have had to survive you?"

Client: "Oh, for her this would have been terrible; how she would have suffered!"

Frankl: "You see, Doctor, such a suffering has been spared her, and it is you who have spared her this suffering; but now, you have to pay for it by surviving and mourning her."

The client said nothing and calmly left the office. At that moment, his suffering had gained new meaning due to being reinterpreted as a sacrifice. That sense of meaning helped the doctor shift his attitude toward the death of his wife so that he could remain open to some of the cognitive restructuring techniques used to address his symptoms of depression.

This type of intervention can be used nicely within the frame of cognitive behavior therapy for severe depression because it helps the client hold on to life through meaning and lessen the severity of despair and suicidal risk. This may serve as the first step, prior to any activity scheduling technique, toward cognitive restructuring. Once the client has made a shift toward an interpretation of meaning, he or she can be more receptive to other types of therapeutic interventions.

Research. Attitude modification could be viewed as both a process-based (controlling and directing the attitude) and content-based (the meaningfulness of our thoughts and actions) technique. It bears a striking resemblance to strategies used in both cognitive-behavior therapy and metacognitive therapy developed by Wells (2009).

Cognitive restructuring and attitude modification have similar focuses: correcting maladaptive thoughts using Socratic dialogue, to facilitate behavior change. In both cases, common sense is applied; however, attitude modification extends one step further by generating personally meaningful options and actions that can maximize well-being.

Metacognitive therapy (Wells, 2009) is process based and focuses on metabeliefs (how one thinks and responds to his or her thoughts). The concept of internal attitude is very similar. It is the position that one chooses to adopt toward his thoughts or condition. Attitude in this case could be viewed as part of metabeliefs. Maladaptive attitudes could be seen as erroneous metabeliefs, whereas adaptive attitudes could be considered as motivating and meaningful.

Furthermore, the *concept of meaning* has been validated by research in logotherapy (Schulenberg & Melton, 2008). The Purpose In Life test (PIL) developed by Crumbaugh and Maholick in 1964 is a valid psychometric instrument and reliable, with alpha coefficients ranging from .86 to .97. It is consistent with the logotherapy postulate and is used to quantify the life meaning concept (Schulenberg & Melton, 2008). The PIL has good utility and has also been shown to be a good predictor of suicidality (Garcia-Adelante, Gallego-Pérez, & Pérez-Delgado, 2009).

Conclusion

The existential component of logotherapy appears to be quite complementary to the techniques and interventions that constitute contemporary cognitive behavior therapy. Incorporating the third human dimension by implementing concepts such as freedom of choice, responsibility, and meaning only serves to broaden the view and understanding of clients and facilitates a segue to change. The logotherapeutic techniques presented in this article have great potential to increase the efficiency of the cognitive-behavioral process in a number of ways. For one, in using the exposure procedure, it can motivate the client to face anxiety or fear by making him/her view it as an option. One cannot always control his or her anxiety level, but can choose

how to react to it. Second, these techniques aid in facilitating perceptual shifts and action by eliminating excuses rooted in the past to counteract the “victim” schema. That is, one is free to choose new behaviors in spite of his or her past learning history and conditioning. Self-distancing through humor can also serve to reduce anticipatory anxiety as well. Lastly, in cases of unavoidable suffering, integrating the attitudinal choice and meaning discovery (one is free to take a stand and discover meaning in suffering) may help the client to better accept and tolerate pain and suffering, reducing the risk for depression, despair, and suicide.

In terms of effectiveness, the integration of the concepts of meaning, personal values, and purposeful goals in the depression protocol individualizes the therapy process and would increase well-being and resilience, reducing the relapse rate. The use of the PIL and VAT in conjunction with cognitive behavior instruments could help assess the risk for suicide and help clients define precise meaningful goals at the end of therapy.

Because logotherapeutic techniques and tools have the potential to increase the efficiency and effectiveness of the therapeutic process, especially in cases that present with an existential struggle, we propose a blending of logotherapy and cognitive behavior therapy to design and validate systematic integrative protocols that could be implemented for specific disorders and issues.

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Call for Papers: Comments on Clinical Supervision Processes

Psychotherapy seeks contributions from practicing psychotherapists on aspects of 'Clinical Supervision Processes'. Clinical supervision processes are driven by theory, clinical experiences, and best available research and practices. These supervisory behaviors or techniques challenge trainees to develop sound clinical judgment, new skills, or ways to conceptualize clients and the process of psychotherapy. They may be things that the supervisor says or does regularly in almost every supervision session, or just occasionally when specific topics are mentioned or events occur. Another way to frame the focus of these papers would be to answer the question: What specific things do you do during a supervisory session that you believe help your trainees learn the knowledge, skills, and awareness to be an effective and competent psychotherapist?

Manuscripts should describe 2–3 such supervisory actions that you believe are important for a useful supervisory session. For each supervisory action included, the author needs to provide information on each of the following areas: a) the theoretical basis for this action and describe how students are expected to gain new knowledge, skills, or/and awareness, b) 2–3 verbatim supervisory exchanges clearly demonstrating this action, and c) any supervisory or research that supports the use of this action. These contributions are to be organized in a series of focused brief comments, 10 to 15 pages maximum (all-inclusive). Each supervisory action described should be only 2–3 pages in length, with each of the 3 content areas outlined above (i.e. a, b and c) being only a few paragraphs.

We are interested in submissions from the widest range of practice orientations, as well as integrative perspectives. Manuscripts submitted must have a very clear statement on the implications for supervision and psychotherapy. As such, papers would need to have very clear and accessible implications for supervisors in applied clinical practice. The suggestions may also be helpful in generating research ideas in the future.

In addition, consistent with the ethical guidelines of the Journal, if clinical case material is reported authors are required to state in writing which criteria they have used to comply with the APA ethics code (i.e. specific informed consent, de-identification or disguise), and if de-identification or disguise is used how and where it has been applied.

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