Integration of Cognitive and Existential therapy

Mixed Methods Research
Part 1: CBT satisfaction and existential thinking online survey - SPSS Analysis of Scales and content / thematic analysis of open-ended questions ***('mixed strand')***
Part 2: An Interpretative phenomenological analysis (IPA) of existential attitude in cognitive therapists ***('qualitative strand')***

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By Dr Melvyn Daniel Flitman

Academic supervisors: Dr Andrew Fox & Dr Werner Kierski

Student Number: M00281603

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Abstract

Presently, ‘cognitive-behavioural therapy’ is an umbrella term. It covers a comprehensive set of heterogeneous, but well-investigated set of behavioural and cognitive psychotherapeutic modalities. Some limitations in their use have been identified, including a certain disregard for the idiosyncrasies of each person. In an attempt to address shortcomings such as these, attempts to integrate techniques and theories from existential modalities have been made. The present research sought to contribute to the investigation of the possibility, viability, and desirability of integrating these modalities, at the level of theory and praxis. Two empirical investigations were conducted. The first consisted of an online mixed-methods survey. Through descriptive and inferential statistics, it explored the views and satisfaction of a large sample of psychotherapists regarding cognitive-behavioural and existentialist psychotherapeutic techniques. Findings showed that many cognitive-behavioural therapists were open to, interested in, and/or utilised existentialist techniques and principles in their practices. Yet, the expected relationship between dissatisfaction with CBT and interest in existentialism was not statistically supported. For the second study, a small sub-sample of cognitive-behavioural therapists, interested in existential therapies, were interviewed face-to-face. Practitioners shared their opinions and experiences of integrating the two types of therapy in their daily practices. Three main themes were identified: Assertion of the Human; Missing Elements; and Integration in Practice. The first theme highlighted how integration brought forward the humanity of clients and therapists. The second theme discussed how integration helped to address limitations of both modalities, making each, in therapists’ opinion, more whole, efficient, and/or complete. The third theme indicated integration was conducted with apparent success for several different practical purposes and reasons. Therefore, from a qualitative viewpoint, the integration of these modalities seemed possible, viable, and desirable. Evidence-based recommendations for practice were offered at the end.

Keywords: Cognitive-behaviour therapy; Existentialist therapy; Integration; Mixed methods; Interpretative Phenomenological Analysis; Clinical practice

Statement of Copyright and Originality

This is an original research project. The Ethics Committee at the New School of Psychotherapy and Counselling provided ethical approval for this work.

Dr Melvyn Daniel Flitman

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Overview

The outline of the present thesis is as follows. Chapter 1 starts by identifying several rationales behind the integration of modalities. Thereafter, it provides the historical background, effectiveness, and limitations of two modalities: Cognitive-Behavioural Therapy (CBT); and Existential Therapy (ET). Finally, from a theoretical and it reflects on the possibility, viability, and desirability of integrating specifically CBT and ET. Chapter 2 specifies the aims and hypotheses of the present research. Chapter 3 explores the methodology embraced for the two studies conducted for this thesis. One is generally referred to as ‘mixed-methods strand’, and the other as ‘qualitative strand’. Chapters 4 and 5 are dedicated to the mixed-methods strand, presenting and discussing its results, whereas Chapters 6 and 7 are dedicated to the qualitative study. In Chapter 8, a final overview of results is offered by comparing and combining the quantitative and qualitative results of both strands. Additionally, recommendations from and for practice are outlined.

Chapter 1 - Cognitive-Behavioural and Existential Therapies: Their Value and Integration Potential

1.1 Introduction

Presently, the most widely practised modality is Cognitive Behaviour Therapy (CBT; Hickes, & Mirea, 2012; Hofmann et al., 2012; Gaudiano, 2013). As it will be substantiated subsequently, this discipline has sought to base its practices soundly upon empirical evidence since its early beginnings. Consistent with this original ambition, CBT is presently acknowledged as the most researched form of therapy (David, Cristea, & Hofmann, 2018; Hickes, & Mirea, 2012; Hoffmann, et al., 2012). Importantly, employed research designs tend to be accepted, by the scientific community, as reasonably scientifically trustworthy, covering meta-analytic, experimental, and group comparison studies (e.g., Djulbegovic, & Guyatt, 2017).

Some of these studies have concluded that CBT was systematically superior, or, at least, not systematically inferior to other forms of psychotherapy for the treatment of specific psychiatric disorders (Beck, 2005; David, Cristea, & Hofmann, 2018). These results apparently informed considerably the recommendations offered by the British National Health Service (NHS), for the treatment of mental health. However, these conclusions have been contested. Many investigators have inclusively empirically observed that the effects sizes of CBT treatments are sometimes low, lower than alternatives, and do not tend to last long (Bennett-Levy, & Lee, 2014; Creed, 2014, Dudgeon, & Kelly, 2014; Freeman, & Garety, 2004; Gaudiano, 2008; Gebler, & Maercker, 2014; Hickes, & Mirea, 2012; Johnsen, & Friborg, 2015; Lazarus, 2015; Norcross, & Hill, 2004; Rhodes, & Jakes, 2009). Then, the efficacy of CBT is not consistently

superior/inferior to those of other modalities, even under very specific circumstances (Cuijpers, Berking, Andersson, Quigley, Kleiboer, & Dobson, 2013; Reid, 1997; Tolin, 2010).

The recognition of CBT's limitations, such as those mentioned above, has led to various kinds of betterment efforts, and to continued research efforts. As Guzick, Cooke, Gage, and McNamara's (2018, p.6) put it, in relation to the treatment of Obsessive Compulsive Disorders (OCD), "*approximately 30–38% of people with OCD do not respond adequately to CBT (…). This has led clinical researchers to investigate augmentation strategies that may bolster the effectiveness of CBT*." For these authors, 'augmentation strategies' included psychopharmacology, and 'psychosocial' approaches. Some of the examples of psychosocial interventions, discussed by the authors, were the inclusion of family members in the treatment plan, and exposure response prevention therapy. These complements would hypothetically increase the efficacy of CBT for the treatment of OCDs.

Since exposure response prevention therapy, mentioned above as an augmentation strategy, is sometimes categorized as one of the many sub-modalities of CBT (Hayes, 2011), developed from within Behavioural Therapy (BT) models, the authors' suggestion would not actually implicate the use of a distinctive psychotherapeutic models. David, Cristea, and Hofmann (2018) made a similar proposal. For the authors, CBT's outcome efficacy could be improved by refining CBT's theories or mechanisms of change (e.g., information processing changes), that is, from within its main paradigms of theory and practice.

An alternative strategy for boosting the 'efficacy' of CBT, as short for therapeutic usefulness, has been to integrate it with diverse, and eventually quite contrasting modalities. This was precisely the main aim of the present thesis. It investigated the psychotherapeutic value of

integrating CBT with a distinctive psychotherapeutic approach, and specifically with Existential Therapy (ET). Some of the main reasons behind this choice of research topic will be disclosed in the following section.

Subsequently, two sections will explore first CBT, and then ET. The objective is to "*provide an overview, synthesis and a critical assessment of previous research*" (Boell, & Cecez-Kecmanovic, 2015, p.161) and theory about the integration of CBT and ET. In each one of these sections, the tenets, practices, singularity, effectiveness, and limitations, of CBT, and, then, ET, will be scrutinized. At the end of the chapter, the possibility, viability and desirability of integrating specifically CBT and ET will be considered at theoretical and evidence-based levels.

Overall, the chapter has thus seven sections: introduction; motivations; state of the art of modalities' integration; state of the art of CBT; state of the art of ET; state of the art of the integration of CBT and ET; and discussion. Each one of these sections will be approached in a narrative manner. Attention will be given to the historical unfolding of some of these debates, as these are generally consensually presented in relevant academic fields. The literature brought to the attention of the reader was fetched mostly with the help of digital databases, per topic of interest, on an argument, counter-argument, then synthesis type of Russellian logic (Russell, 1908). Moreover, the strategy used for reviewing theoretical literature differed from the one used to explore empirical issues.

Namely, when focusing on theoretical aspects, preference was given to papers put forward by the said-to-be main founders of particular schools of thought, psychotherapeutic modalities, or ideas. The objective was to remain close to original texts, all while trying to prevent 'word of

mouth' distortions as best as possible. Again, the notion of original or main founder is a subjective judgement, performed here to the best of the author's ability and knowledge of relevant academic literature, and may, as in fact any other claim, be contested.

On the other hand, when reviewing empirical results, preference was given to meta-analytical studies, or papers published in this century, from the year 2000 onwards. Empirical methods have evolved greatly, and, on the (eventually hopeful) premise of lessons learnt, more recent high quality empirical studies deemed better older studies. Additionally, as noted, an utterly extensive amount of empirical research was found, particularly about CBT. Then, this choice became a practical necessity in a study which did not aim to conduct a systematic review study, which is a study in and of itself. It was merely to understand and contextualize the topic under study for the reader, in all its complexity, and as understood in this thesis. Therefore, whatever the reasons behind the above literature review choices, and despite the author's best intentions and efforts, it is quite possible that some studies, and even core studies might have been overlooked in this review process.

1.2 Main Personal Research Study Motivations

My choice of investigating the integration of ET and CBT was greatly influenced by my academic and professional background, and aspirations. I had been trained in ET, as an existential Psychotherapist. However, to obtain a placement within the NHS, I was advised to study Rational Emotive Behaviour Therapy (REBT), at the Albert Ellis' Institute course in Birmingham University, and CBT, in Aaron Beck's institute. This recommendation alerted me to preference of NHS for these modalities, as opposed to ET. Nevertheless, ET was still represented under the form of REBT.

The intent to better understand how ETs and CBTs could be more extensively integrated was nothing particularly new. As I, Albert Ellis, the founding father of REBT, was quite interested in integrating ET with the sub-modalities of CBT available at the time (Ellis, 2005a). My motivation was further boosted by my interactions with my REBT supervisors and teachers, during Primary and Advance practicum. The lecturers often mentioned the role of existential philosophers in assisting clients to achieve philosophical change which was REBT's main psychotherapeutic goal. One of my REBT tutors inclusively confessed to have had desired to have been trained by Emmy Van Deurzen, who is generally acknowledged as the founder of one specific ET, Structural Existential Analysis (SEA).

As a consequence of my training, I felt comfortable applying the CBT, ET, and REBT in my NHS placement. With clients, I explored the existential dimension, via ET and REBT. I ended up gaining the impression that this therapeutic choice was both welcomed and beneficial, as inclusively empirically found (e.g., Gebler, & Maercker, 2014). I became keen on understanding the experiences of other psychotherapists and clinical psychologists undergoing similar practices, and particularly in NHS settings, where ET was not greatly valued. This was particularly important for the integration of sub-modalities of ETs and CBTs lacked guidelines, and much less detailed guidelines. This meant that decisions regarding when, why, or how integration was to be achieved rested mostly on clinicians' shoulders, on my shoulders. In some moments, I felt insecure about these decisions, such as when put to question by clients or institutions. On the upside, I started to feel very strongly that understanding integration, from the ontic experience of practitioners, potentially represented fertile grounds for research. It seemed a study worth pursuing.

The above are the main reasons behind my research topic choice – or at least those of which I am aware of. Throughout the thesis, wherever felt appropriate, reflections about how these reasons might have biased my conclusions and observations, such as in *section 7.8,* are offered.

1.3 Integrating Modalities: Not Necessarily a Necessity

In the following sections, the recommendations of the National Health Service (NHS) for the treatment of mental health are disclosed. With the help of a statistical phenomenon, it follows a discussion of the presumptions behind these recommendations, and behind every integrative effort. At the end of this section, diverse forms of integrating modalities are presented. The aim is to clarify the methodological possibilities faced by those who are knowingly integrating modalities, as the present study.

1.3.1 The recommendations and practices of National Health Service

The National Health Service (NHS) is the publicly funded healthcare system in England. Its intention is to "*optimise outcomes*" (National Collaborating Centre for Mental Health, 2018, p.13), as based on available evidence. Such a "*process of systematically finding, appraising, and using contemporaneous research findings as the basis for (...) decisions*" (Tonelli, 2006, p.248) has become "*the current clinical dogma*" (Isaacs, & Fitzgerald, 1999, p.1618) and "*the emergent norm in assessing therapy effectiveness*" (Hoffman, Dias, & Soholm, 2012, p.11). Scientists, including social scientists and clinicians, are asked to follow evidence (Hickes & Mirea, 2012; Hoffman et al., 2012; Murad, Asi, Alsawas, & Alahdab, 2016; Tonelli, 2006), as opposed to, for example, logical reasoning, or common sense.

Moreover, a hierarchy of evidence is generally embraced. It sets as better quality evidence, of greater scientific 'proof-of-worth', Randomised Control Trials (RCTs) and their meta-analyses and systematic reviews (Djulbegovic, & Guyatt, 2017; Murad et al., 2016). RCTs have at least two comparison groups, the control and the intervention group, adopt randomisation procedures for assigning participants to conditions, are diagnosis-oriented, and adopt manualised treatments with measurable population-specific outcome goals (Seligman, 1995). Beginning in the 1990s, low to high quality empirical studies, investigating the efficacy of psychotherapeutic modalities, have proliferated.

However, the evidence pyramid cannot be accepted blindly. First, it must be determined if each study, inclusively when included in meta-analyses, shows satisfactory validity and reliability, for quantitative paradigms, or trustworthiness, for qualitative paradigms. There are degrees to how good an RCT, or any other research design, really is, and to which extent its findings should be granted some scientific value of truth. As Djulbegovic, and Guyatt (2017, p.416) put it, "*what is justifiable or reasonable to believe depends on the trustworthiness of the evidence, and the extent to which we believe that evidence is determined by credible processes.*"

To establish an evidence-based approach to mental health, the NHS embraced National Institute for Health and Care Excellence (NICE) guidelines. In 2008, it implemented progressively, all over England, the Improving Access to Psychological Therapies (IAPT) programme in its mental health institutions and organizations.

In IAPT, "*progressively intensive psychological treatments are made available to patients according to need (…). Patients are initially offered brief (≤8 sessions), low-cost, and low-intensity Guided Self-Help (GSH) based on principles of cognitive behavioural therapy*""

(Wakefield, Kellett, Simmonds-Buckley, Stockton, Bradbury& Delgadillo, 2021, p.2). Therefore, according to the NHS, there is one treatment, GSH, which is expected, if not to benefit everyone, than at least not harm them. It is CBT-based, and might be generally described as a boost to self-knowledge, autonomy, and/or empowerment.

If this treatment step proves inefficient, and the client does not improve, more intensive treatments, of longer duration, are made available. As detailed by IAPT, to a great extent this involves matching clients' diagnosed disorders to specific treatments. As specified in their "*Table 2*" (National Collaborating Centre for Mental Health, 2018, p.14-5), possible treatments include CBT, Behavioural Activation, Couple therapy, Brief psychodynamic therapy, exercise, and so forth. Then some, but not every of these treatments are referred to by modality. In some cases, specific techniques are mentioned instead, such as 'Behavioural Activation'. As for listed disorders, these include depression, OCD, several anxiety disorders, chronic pain, and so forth.

The treatment specifications above denounce NHS's compliance with the notion that there are better treatments, and particularly, better treatments for the treatment of specific disorders. Simultaneously, it acknowledges there are treatments, such as self-help, that apply to all cases and persons. Yet, as mentioned previously for the case of OCD, this does not mean that either solution, from general to specific, is efficacious for every case. This observation will be explored in more detail in the following section.

1.3.2 The 'Equivalence Paradox'

As previously suggested, it has been argued in the literature that every psychotherapeutic approach has limitations in scope. None can be used successfully to treat every ailment, in every circumstance, and/or everyone (Lazarus, 2015; Norcross & Goldfried, 2005; Zarbo, Tasca, Cattafi, & Compare, 2016). Moreover, "*despite manifestly non-equivalent theories and techniques*" (Stiles, Barkham, Mellor-Clark, & Connell, 2008, p.678), the breadth of this fallibility has been found to be fairly statistically similar across approaches. For example, the positive outcomes of CBT, person-centred therapy, and psychodynamic/ psychoanalytic therapy, as practiced routinely within the British National Health Service (NHS) with the very large sample of 5613 patients, is similar in magnitude (Stiles, Barkham, Mellor-Clark, & Connell, 2008). This was very much so regardless of whether it was used in isolation or in conjugation with one other psychotherapeutic approach.

Researchers coined this observation the "*equivalence paradox*" (Stiles, Barkham, Mellor-Clark, & Connell, 2008, p.678), or the "*Dodo bird effect*" (Wampold, et al., 1997, p.203) or 'verdict' (Middleton, Shaw, Collier, Purser, & Ferguson, 2011). As detailed by Mulder Murray, and Rucklidge (2017, p.953), "*15 of 17 meta-analyses comparing active treatments with each other showed small, non-significant differences in outcome, which diminished further after the substantial effects of researcher allegiance were controlled for*." In sum, the efficacy of modalities was apparently barely undiscernible (Goldfried, 2009; Hickes & Mirea, 2012; Mulder, Murray, & Rucklidge, 2017; Stiles, Shapiro, & Elliott, 1986; Tolin, 2010). Additionally, interestingly, to boost efficacy, practitioners should opt for modalities of their personal preference. As it happens with placebo drugs, their beliefs were responsible for part of treatment outcomes.

Discovering that the efficacy of diverse modalities is rather similar, and none is best, can be fairly disheartening for those competing over which modality is best, and willing to defend their own corner. It can also be disheartening for positivist thinkers, hoping to ground their clinical decisions on statistical quantitative data, or needing to apply IAPT treatment recommendations. As it has been acknowledged, it is "*an inconvenient truth*" (Middleton, Shaw, Collier, Purser, & Ferguson, 2011, p. 155) that evidence is, or still is "*only of limited application to the understanding of mental health difficulties and how they might be addressed"* (p. 155).

In summary, it has been empirically shown that the efficacy of every modality was low to moderate. Moreover, every modality was apparently similarly limited, apparently showing equivalent efficacy levels. This finding can be problematic for everyone embracing evidence-based approaches, inclusively for subscribing to NHS's treatment recommendations.

1.3.3 Explanations for the equivalent paradox

An explanation for the equivalence paradox involved the inadequacy of quantitative paradigms, and in particular as personified by RCTs and their meta-analysis, for investigating the value of psychotherapy, and its mechanisms of healing (Beauchamp, & Childress, 2001; Bloch, & Green, 2006; Garbutt, & Davies, 2011; Gabbard & Ogden, 2009; Hawkes, 2018; Hoffmann, Bennett, & Del Mar, 2017; Kingdon et al., 2010; Krauss, 2018; Murad et al., 2016; Parloff, 1980; Quinsey, 1973; Scott, 2011; Seligman, 1995; Tolin, 2010). This research object may simply be too complex for available scientific research techniques (Cook, Schwartz, & Kaslow, 2017; Hawkes, 2018; Krauss, 2018). As Elliott (2011, p. 70) expressed, "*quantitative process-outcome research designs are blunt instruments for understanding anything as complex and*

nuanced as the process of change in psychotherapy or other mental health interventions" (Elliott, 2011, p. 70).

Moreover, research conclusions cannot be taken as a set of universal, bullet-proof truths, inclusively the equivalence paradox itself. There are many historical instances where statistical methods (e.g. omission of effect sizes and lack of awareness of the reasoning behind probabilistic procedures; Hoffmann, Bennett, & Del Mar, 2017), research designs (e.g. surveys not accounting for social desirability effects; Fisher, 1993; Gittelman et al., 2015) and established conclusions (e.g., Francis Gall's phrenology; Lazarus, 2015) have been considerably challenged. This does not mean that therapists must be scholars in every discipline, but rather that they must reserve some level of scepticism when comprehending published evidence and do so on a case-by-case basis (Jutkiewicz, 2006).

Seligman (1995, p.966) went as far as saying that "*the efficacy study is the wrong method for empirically validating psychotherapy as it is actually done*". Mulder Murray, and Rucklidge, (2017) went further by proposing research on psychotherapy should start to cover transdiagnostic treatments, which are outside the scope of RCTs, and to more often inspect mechanisms of change, including at the level of neuropsychological evidence, which is presently still not the case.

A second explanation for the equivalence paradox consists of the 'common factors' hypothesis (Cuijpers, Reijnders, & Huibers 2019; Middleton, Shaw, Collier, Purser, & Ferguson, 2011; Mulder Murray, and Rucklidge, 2017; Wampold, 2015; Zarbo et al., 2016). It proposes that every psychotherapeutic encounter enacts an equivalent set of psychosocial processes. These 'factors' would contribute jointly to observable positive therapeutic outcomes, and their lack

thereof. Lampropoulos (2001, p.8) unpacked, "*the common factors approach is the search for common elements in all effective therapies regardless of the varying terminology*" (Lampropoulos, 2001, p.8). Examples of factors range from feelings of safety, unconditional acceptance, and understanding (Middleton, Shaw, Collier, Purser, & Ferguson, 2011), all of which concerned with clients' experience, to adherence, alliance, positive expectations, competency perceptions, behavioural change, empathy, and cultural adaptation (Wampold, 2015), where some factors are also concerned with therapists' performance or client-therapist relationships.

Common factors proponents could for example propose NHS embraced this presumption when proposing, as a first treatment step, GSH low intensity treatments. These treatments can be said to enact general processes, such as self-knowledge, autonomy, and empowerment. Thus, this step can be embraced as CBT-based, but fairly general, and, if not transmodality, than at least transdiagnostic. The common factors explanation sometimes comes hand in hand with the presumption that specific theoretical models and/or techniques have null impact on the outcomes of therapy (Mulder, et al., 2017). Yet, this is a fallacy.

Specifically, the common factors model, or theory, or explanation has been used to explain the equivalence paradox alongside the herein coined 'granularity assumption'. It proposes that modality-"*specific factors*" (Mulder, Murray, & Rucklidge, 2017, p.953), such as modality-specific technics and mechanisms of healing, explain, in a statistical sense, part of the efficacy of that modality for addressing specific disorders, persons, and/or circumstance (Bernecker, Coyne, Constantino, & Ravitz, 2017; Hayes, & Hofmann, 2018; Mulder et al., 2017). This is precisely the presumption of the NHS when recommending certain more intense treatments for certain, more serious cases. When seeking to understand the equivalence paradox, all while

accepting the value of specific modalities, Hayes, and Hofmann (2018) argued that, hypothetically, the differential value brought along by each modality, in each particular case, might end up adding up to a state of apparent general equivalence, when taken as a whole.

Beyond the disorder itself, specific granular factors have not been fully and systematically explored. Nevertheless, aspects to which clinicians can be sensitive to, when making treatment choices, include clients' the socio-demographic attributes (e.g., education, and age), types of presenting problems (e.g., anxiety, and psychosis), therapeutic aims (e.g., symptom remission, and coping), and therapeutic tools (e.g., CBT's 'Socratic questioning' technique, the behavioural 'exposure' technique, and the psychoanalytic introspection technique).

In summary, the equivalence paradox has been explained by arguing in terms of the inadequacy between research methods and research objects, of the value of general factors for treatment outcomes, and of the macro-level dilution of the value of specific factors. Among these explanations, the NHS apparently embraces two. One refers to the value of common factors, as in the case of first step approaches to the treatment of mental health. The second refers to the granularity assumption which states that modalities have differential value. The latter is also particularly important for anyone undergoing integration efforts. One must believe, presume or support that each modality has its own merits to seek to combine these merits, generally discussed in terms of heightened efficacy, in the pursuit of the integration of modalities. In the following sections, the assumptions, objectives, and forms of integrating modalities will be unpacked.

1.3.4 Combining Distinctive Psychotherapeutic Frameworks

As the recommendations of the NHS, the present thesis also embraces the granularity assumption, when exploring the differential value of modalities. Additionally, it embraces the 'additive integration' presumption, which argues that the combination or the integration of two or more modalities heightens the therapeutic scope, benefits, and/or efficacy of single modalities (Mulder, et al., 2017). As revealed in preceding sections, this hypothesis can be contested, from the viewpoint of the equivalence paradox, which shows that modalities have equivalent efficacy. It can also be contested from the perspective of common factors' models, which lessen the value of specific modalities in favour of the processes enacted by every modality.

Nevertheless, the granularity assumption has a long history in the field, and in such way that alternative forms of thinking about clinical psychology may suffer increased resistance. In the beginning of the 20th century, when Psychiatry was raised to the level of a science, key psychologists and psychiatrists were mostly keen on defending their own territory and views of how mental health could be explained and fomented. There was little willingness to enter in dialogue with psychologists with different clinical perspectives, or disregard one's own modality as equal in efficacy to any other. This is to say that "*practitioners were polarized into distinct camps of rival schools (…). Although remnants of these 'therapy wars' unfortunately remain, there is certainly more support for an ecumenical approach*" (Norcross, Beutler, & Goldfried, 2019, p. 318).

In the turn of the 21th century, the picture of conflict depicted above slowly begun to change. The cross-modality dialogue had been enacted, and was flourishing. There already were "*dozens of specific systems*" (Norcross, Karpiak, & Lister, 2005, p.1587) for integrating

modalities, and "*literally hundreds of books*" (p.1587) on integrated modalities or integrative processes. Most these theories and practices not assumed that each modality had a specific value, but also that their combination enhanced the value of each modality. This presumption is referred throughout this thesis as the 'additive integration' hypothesis. It proposes that the merits of each approach add on to one another. As such, integrating modalities would bring advantages, if not in terms of efficacy, than at least in terms of scope.

Several forms of pursuing additive integration, and evaluating its benefits, have been proposed in the literature (Norcross, Karpiak, & Lister, 2005). These can be divided into two main strategies. One seeks to integrate techniques of diverse theoretical origins, as with the case of technical eclecticism and integrative medicine. The other seeks to integrate both techniques and theories, as with the case of assimilative integration. The following subsections will describe these strategies in greater detail.

1.3.4.1 Technical Integration: Technical Eclecticism and Integrative Medicine.

For more than five decades, Arnold Lazarus has been a staunch defender of technical eclecticism, and a staunch opponent of theoretical integration (Lampropoulos, 2001; Lazarus, 2015; Lazarus, & Beutler, 1993). Technical eclecticism involves having therapists pragmatically choose psychotherapeutic techniques for their proven effectiveness, and regardless of their theoretical provenance (Beutler et al., 2016). For Lazarus (2015, p.166), the choice of methods should be guided by scientific proof-of-worth, and scientific proof-of-worth alone. Until such proof was gathered, technically eclectic clinicians were recommended to *"exercise extreme caution*" and avoid "*falling prey to every fad.*"

Throughout the years, the keyword of Lazarus' argument was 'proven'. Technically eclectic clinicians were expected to tackle each issue of someone's condition one-by-one, objectively and systematically, through the use of empirically supported interventions. This approach recently evolved into the "*multimodal therapy*" (Lazarus, & Lazarus, 2019, p.125). It still is mostly an atheoretical framework approach to integration. It divides the systematic assessment and treatment of clients per area of functioning (Lazarus, & Lazarus, 2019).

An approach resembling Lazarus' technical eclecticism is Bell et al.'s (2002, p.133) "*combination medicine.*" It seeks to justify and eventually guide the use of "*conventional and alternative techniques (…), once tested and proven effective*" (Bell et al., 2002, p.134), and regardless of their theoretical provenance. Nevertheless, physicians using combination medicine are expected to redirect patients to other experts when they see benefit in a (traditional, or not traditional) technique they themselves do not master, or is simply outside their expertise. Say, no-one expects the General Physician (GP) to apply acupuncture, and be evaluated in that area.

Unlike wise, a technical eclectic psychotherapist or clinical psychologist is being asked to use every technique, even when, as physicians, psychotherapists potentially know little about, lack training, disagree with, and/or distort the application of techniques, and principally those from distinctive modalities (Messer, 2001). Additionally, whereas Bell and colleagues offered 'complex systems theory' as an overarching explanatory framework, justifying the aggregation of diverse techniques, it took a long while for Lazarus (2015, p.166) to develop his very own "*super-organizing (…) superstructure*", which was initially deemed unnecessary. It was coined, as noted, multimodal therapy.

In any case, as with aforementioned common factors models, integrative medicine, and technical eclecticism, are mostly atheoretical, and still poses "*complex practical and conceptual issues*" (Bell et al., 2002, p.133). For one, the 'proven' worth of techniques, factors, and even, to some extent, modalities, is rather hard to establish in a field like psychotherapy. In this area, psychotherapeutic techniques or tools often amount to constructs, with few, unknown, or at least debatable material and quantitative measures, and procedural definitions.

In these circumstances is for example the Socratic questioning tool. It is very often discussed in CT as useful for cases of depression (Carey, & Mullan, 2004). Nevertheless, this recommendation is not soundly resting of unquestionable evidence. Specifically, according to Braun, Strunk, Sasso, and Cooper's (2015) own review, theirs was the 'first' empirical evidence illustrative of the positive and independent impact of Socratic questioning on the session-to-session improvement of depressive symptomatology. Up until their study, conducted in 2015, this tool had apparently been recommended, used, and seen its outcomes assessed at best as part of therapists pool of CT or CBT's techniques. Any of the CTs techniques used by the therapist, and even something else such as an aforementioned common factor, might be explaining the extent of the success of the therapeutic process for minimizing or eliminating depressive symptomatology.

Moreover, the technique itself is hard to, and has not yet been very detailed at a very concrete, moment-to-moment level. Even in Braun, et al.'s (2015) study, Socratic questioning was operationalized as having therapists ask "*a series of graded questions to guide patient behavior and thought processes toward therapeutic goals*" (Braun, Strunk, Sasso, & Cooper, 2015, p.32), and "*foster active engagement and critical thinking*" (p.33). Two different therapists may interpret these guidelines very differently, particularly at the concrete level of behaviour

and/or intention, and its efficacy necessarily needs to be assessed in relation to the set aim. Otherwise, confounding variables might be actually statistically be explaining its apparent success.

The point is that the list of psychotherapeutic techniques with solid proven worth is likely rather thin. Studies about their value have several validity and reliability issues, inclusively when conducted under the form of an RCT, and thereafter included in meta-analysis (Hoffmann, Bennett, & Del Mar, 2017). This is very much so even when these tools and modalities are advocated by social structures, such as the NHS.

Moreover, as in medicine, mastery over psychotherapeutic techniques may matter in psychotherapy. The psychoanalytic free-association introspection tool can become an objective identification of factual causes and consequences at the hand of a CT clinician, trained in Socratic questioning. A factual or logical description cannot possibly stem from the Id, which lacks rationality by definition, and is to be triggered via free association and introspective techniques. Even if the eclectic therapist learnt the lesson well, and refrains from talking and making questions during an introspective free-association exercise, a client who has been treated by that very same therapist in terms of CT techniques might respond to the proposition of a free association exercise in ways that echo past, rewarded, and learned cognitive exercise performance (Strieker, 1996).

Despite the criticism discussed above, valuing ‘technique’ or ‘factor’ over theory has been described as a necessity “*by default*” (Norcross, Karpiak, & Lister 2005, p.1588), and the *“ethical*” (Lazarus, 2015, p.166) attitude to hold. It is argued to allow clinicians to exercise

their practise benevolently, to the best of their judgement, in accordance with the deontological professional code, "*providing benefits to clients and stakeholders when the opportunity to do so is present*" (e.g., Bates, 2004, p.341). Not using some apparently successful technique might even be argued to represent an infringement on their medical ethical obligations.

In summary, there have been psychotherapists who argued in favour of choosing evidence-based techniques, regardless of their theoretical origins, or logical and theoretical compatibility. This option has even been argued to represent psychotherapists' most ethical clinical orientation. Criticism to approaches valuing technique over theory has been put forward by those arguing sufficient empirical evidence is lacking, making the choice of techniques impossible to ground on available evidence. Criticism to technic-oriented models has also been formulated by those arguing in favour of the clinical value of theory, inclusively on integrative practices. Some of these also theory-oriented alternatives will be explored in the following section.

1.3.4.2 Conceptually integrated models: Assimilative Integration

Strategies for integrating diverse modalities and their elements at theoretical, and/or conceptual levels, have been proposed (Lazarus, 2015; Norcross, & Goldfried, 2005). According to Lampropoulos (2001, p.7), 'theoretical integration', one of such strategies, was even *"the most difficult route for psychotherapy integration*", and, if not "*impossible*", at least "*premature"*. This was in part for the even greater lack, when compared to techniques, of satisfactory scientific testing of theoretical hypotheses (Lampropoulos, 2001; Lazarus, 2015). Specifically, as an example, it has not been established if some specific psychopathology is 'cured' better, or more swiftly, by changing people's behaviour, versus changing thinking patterns, versus

changing their self-awareness of subconscious and unconscious drives, or even 'all of the above'. Hence, the use of evidence to select best, or better theoretical assumptions and models is debatable, and even more debatable than the use of evidence in support of specific techniques.

For Lazarus (2015, p. 166/167), this lack made whatever model integrating theoretically diverse psychotherapeutic modalities "*subjective"*, "*unsystematic*", "*synthetic*", and "*random*", illustrative of the "*hidden rules of clinical algorithms and heuristics*", and of "*basic paradigmatic incompatibilities*". Yet, as noted, evidence regarding techniques is also not of great statistical quality.

A strategy for integrating theories and constructs more systematically than Lazarus was likely conceiving is through the process of 'assimilative integration' (Lampropoulos, 2001; Norcross, 2005; Zarbo et al., 2016). This approach to integration consists of progressively and systematically integrating, into a higher-order structure, diverse types of elements, from techniques, to concepts, or theories. This is to be conducted by evaluating the value of the element at empirical, 'assimilative', and then 'accommodative' levels. As Messer (1992, p.2) put it, the theory developer should consider the:

> conceptual fit within the different theoretical and therapeutic framework (its accommodative aspect); its clinical meaning within the new therapeutic context (its assimilative aspect); and the empirical validity of its efficacy (its scientific aspect), which must be established anew.

Then, beyond the empirical level, which has been discussed previously, at some length, in relation to technical approaches to integration, and to the practices of the NHS or common

factors models, Messer stressed the importance of understanding if the new element was conceptually logically compatible with the whole, and thereby demonstrated assimilative potential. Messer also stressed the importance of articulating the resulting "*new assimilative integrative model*" (Lampropoulos, 2001, p.9). This new model should be expressive of every element put together, in their accommodated meaning. Thereafter, it required comprehensive scientific retesting, before proceeding to the integration of new elements into the model. Therefore, the overall process of integrating whatever element into a practice was not immediate or limited to technical elements, and it nevertheless demanded testing.

Cognitive Analytic Therapy (CAT; Lampropoulos, 2001; Norcross, 2005; Ryle, 1993) has been described as the result of an "*assimilative integration*" (Strieker, 1996, p.50) process. It integrates understandings from psychodynamic, "*cognitive, and constructivist*" psychotherapies (Ryle, 1993, p.193). Then, each assumption and tool is explained in the light of these three modalities (Messer, 1992). Its theory-, and evidence-based manualised six-month psychotherapeutic treatment targets three areas: "*overt behaviour*"; "*conscious cognition, affect, perception, and sensation*"; and "*unconscious mental processes, motives, conflicts, images, and representations of significant others*" (Strieker, 1996, p.50). Overall, CAT, via assimilative integration methods, offers a conceptually integrated modality, and clinical practice guidelines. It seeks to provide "*some coherent framework for predicting and understanding change and for determining choices of therapy procedures*" (Arkowitz, 1992, p. 263).

In sum, two main approaches to integration have been put forward. One revolves around the aggregation of evidence-based psychotherapeutic techniques. The alternative seeks to integrate theories, concepts, and techniques into a coherent whole, eventually progressively and into a

testable shape, such as with the method of assimilative integration. Both approaches have been criticised, and none has been shown as superior. In part, criticism arises for the difficulty in establishing the proof of worth. Clinical psychology techniques, or theories, and their effects (or, better said, statistical behaviour) share a considerable degree of hard-to-quantify subjectivity, and hard-to-scientifically-demonstrate objectivity, even for the greatest psychometry investigators.

This thesis is concerned with psychotherapists' experiences of integrating two particular psychotherapeutic modalities: ET and CBT. From this point onward, the term 'integration' will be used to refer to the combination of approaches in whatever shape and form, and at whatever level, technical or theoretical, and most commonly as the term itself was understood by study participants. Nevertheless, some degree of generalizability of the discussion held here regarding integration is expected to apply, Additionally, for the sake of some argument, types of integration approaches, such as 'technical eclecticism' or 'assimilative integration', can also be referred to by name in subsequent sections.

1.4 The Value of CBT(s)

1.4.1 CBT as a general, institutionally recommended practice

The term CBT is recurrently utilized in the literature in a rather general way, to refer to what is said to represent the most common type of approach to the treatment of mental health issues in Western countries (Fenn & Byrne, 2013; Thoma, Pilecki, & McKay, 2015). It is further said to embrace the medical psychiatric approach to mental health, and to offer evidence-based, usually short-term, protocol-driven treatments for diagnosed mental disorders (Gaudiano,

2008; Hickes, & Mirea, 2012; Hofmann et al., 2012; Paley et al., 2008; Williams, & Garland, 2002a).

It has two main aims (Fenn, & Byrne, 2013). The first is to help people to understand their current ways of thinking, feeling, and behaving. The second is to support the change of maladaptive, distressing patterns. Thus, the first step of therapy is to establish a problem, most commonly described as a psychiatric disorder or a distressing pattern of fucntioning. This problem is usually a symptom-based diagnosis, mostly concerned with maladaptive cognitions, though eventually also revolving around behavioural, physiological, and/or emotional aspects. The subsequent step is to seek to resolve the problem, through a set of pre-defined, manualized strategies. The ultimate aim of the treatment tends to be symptom minimisation or remission, and eventually the improvement of overall functioning and well-being.

When the term CBT is used in these indiscriminate terms, it also tends to be described as "*atheoretical*" (Knapp & Beck, 2008, p.s55), "*metatheoretical*" (Hayes, 2004, p.640) or "*theoretically complex*" (Hupp, Reitman, & Jewell, 2008, p.263) aggregation of techniques. This lack of consistency denounces perhaps difficulties in identifying the theoretical framework behind 'CBT', as a vaguely defined, broad category of psychotherapeutic practices. That is, it resembles a technically eclectic broad modality, as technical eclecticism was previously described (Lazarus, 2015), and with hard, if not irrelevant underlying theoretical tenets. It is also in these terms that CBT became quite the favourite of the British National Health Service (NHS), since the Improving Access to Psychological Therapies (IAPT) program (Clark, 2011; Paley et al., 2008) was launched in 2008.

The IAPT *"is a large-scale initiative (...) particularly focused on cognitive behavioural therapy*" (Clark, 2011, p.318), and specifically as its use is recommended by the National Institute for Health and Clinical Excellence (NICE; Clark, 2011; Dryden, 2009; Hickes & Mirea, 2012). NICE guidelines favour evidence-based therapies, in detriment of clinical experience-based practices (Paley et al., 2008), and recommend the use of 'CBT' for depression and anxiety disorders of any severity (Clark, 2011). Nevertheless, NICE also offers some alternatives. For the treatment of mild to moderate cases of depression, these alternatives include interpersonal psychotherapy, behavioural couples' therapy, counselling, and brief dynamic therapy (Clark, 2011). Telephonic guided self-help and computerised CBT are additional alternatives to be used for the treatment of milder disorders (Clark, 2011).

Regardless of type of treatment, under IAPT, and following NICE guidelines, clinicians are expected to adopt a stepped-care approach, which begins with (an often survey-based) diagnosis and moves along to the application of the evidence-based, condition-specific CBT techniques. The whole process is expected to be quantitatively monitored session-by-session, and should unfold over the course of six to eight sessions in primary care, although substantially more in secondary and tertiary care. This is so much so even when adopting alternatives which are not quite so manualized as CBT, such as brief dynamic therapy.

Then, these institutions seem to implicitly define CBT as a technically eclectic practice, where theory, or notions of mechanisms of psychological change, is less relevant than evidence of therapeutic success. Yet, for practical reasons even, more evidence is naturally available for short-term, manualised, diagnostic-based and measurement-oriented practices, among which most CBT practices can be found (Hoffmann, Bennett, & Del Mar, 2017; Paley et al., 2008; Rhodes & Jakes, 2009; Scott, 2011). For example, longer-term treatments seem to

comparatively lack empirical research (Yakeley, 2014). Thus, it unsurprising that the NHS, IAPT, and NICE have focused on, and recommended mostly CBT (Dryden, 2009). Therapies that are less appropriate candidates for RCTs, and, as such, less likely supported by high-quality evidence, tend to be disregarded (Dryden, 2009).

In summary, CBT is a label often used in indiscriminate, general terms, to refer to an evidence-based, manualized, short-term approach to mental health, with diffuse theoretical assumptions. It is in this general manner that CBT tends to be recommended as NHS's non-pharmacological treatment of choice for most psychiatric disorders (Paley et al., 2008; Parker, Roy, & Eyers, 2003). A couple of alternatives are also offered for certain conditions, of mild t moderate severity. When IAPT is embraced, the application of CBT is to be structured by objective protocols, assessment-guided, diagnostic-oriented, and condition-specific methods. In the following sections, more specific ways of referring to CBT will be explored.

1.4.2 Types of CBTs

The label CBT is also sometimes applied to describe a group of diverse therapies, thereby working as an "*umbrella term*" (Knapp & Beck, 2008, p.s55). In this case, it is further sometimes argued to cover modalities from three distinctive moments in time, often referred to as first, second and third-wave CBT modalities (Gaudiano, 2008; Hayes, 2011; Herbert & Forman, 2011; Prasko et al., 2012; Trower, Jones, & Dryden, 2016). Among these modalities one can find Burrhus Skinner's Behavioural Therapy (BT), Aaron Beck's Cognitive Therapy (CT), and Albert Ellis' Rational Emotive Behaviour Therapy (REBT).

As it will be explored in detail in the following sections, the variety of modalities under the CBT umbrella is so heterogeneous in theory and practice, that it covers modalities with opposing views on the most fundamental issues, such as whether or not changing people's thoughts about their circumstances matters. This variety is so great it could even perhaps justify the use of the term 'CBTs', and opposed to CBT, as proposed with the heading of this section.

It was perhaps such acknowledgement that led Albert Ellis share the opinion that it was, not only hard, as it was 'impossible' to pinpoint that which was shared across these 'CBTs', at theoretical and practical levels. As Ellis (2003, p.225) noted:

> It is almost impossible to describe CBT accurately. Although it was originally, in the 1970s, close to both REBT and CT in theory and practice, it has now become much more eclectic and integrative, so that it includes a wide variety of cognitive and behavioural techniques—as it always did— but also often includes more experiential, interpersonal relationship, existential, humanistic, and other methods than it did previously (Ellis, 2003, p.225).

As acknowledged by Ellis, above, CBT not only was, as it has become increasingly more varied in theoretical and technical scope. Therefore, CBT, as the historical unfolding of several psychotherapeutic modalities, which do not necessarily share the same assumptions and practices, and as recommended by the NHS and NICE, can perhaps only be understood from the viewpoint of 'technically eclecticism' (Lazarus, 2015). The focus is on testing the efficacy of specific techniques (Hayes, 2004), rather than on unifying theoretical specifications. What is being recommended is the protocol put, or even perhaps 'pushed forward' by mental health institutions. It is not a theory of any kind.

The following sections explore the history of the development of CBT. It will do so by unpacking the modalities advanced within each historical period of the development of CBTs, from first to third wave. This description will illustrate well the diversity and technical and theoretical heterogeneity of CBT modalities discussed above.

1.4.2.1 First-wave CBT

The first wave of CBT "*spanned the 1950s and into the 1960s*" (Herbert & Forman, 2011, p.4). According to Lazarus (2015, p.165), "*prior to 1950, psychotherapy and psychoanalysis were virtually synonymous*." Yet, many dissident forms of therapy and schools of psychological thought were already forming by then. These movements gained fuller expression during the 1950s, during a decade which has been referred to as 'first-wave CBT' (Hayes, 2011; Herbert, & Forman, 2011). Among first-wave CBT modalities, one can find Burrhus Skinner's Behavioural Therapy (BT), and, more controversially, Albert Ellis' Rational Emotive Behaviour Therapy (REBT).

BT was greatly influenced by John Watson's (1878-1958) behaviourist manifesto, which sought to rid science of investigations of unprovable concepts like 'soul' and 'consciousness' (Baars, 2003), including Sigmund Freud's introspective methods. For Watson:

> psychology as the behaviourist views it is a purely objective experimental branch of natural science. Its theoretical goal is the prediction and control of behaviour. Introspection forms no essential part of its methods, nor is the scientific value of its data dependent upon the readiness with which they lend themselves to interpretation in terms of consciousness (Watson, 1913, p.158).

As Watson noted, behaviourism values objectivity and the empirical testing of chains of measurable stimuli and observable behaviour. It dismisses, as unscientific, explanations anchored in internal, and 'invisible' aspects, including cognition (Hayes, 2011; Skinner, 1987; Watson, 1913). This manifesto influenced Skinner's (1904-1990) philosophy, coined radical behaviourism, which stands behind the first form of BT, and its several derivative schools of practice (Baars, 2003; Hayes, 2011; Skinner, 1987), such as Clinical Behavioural Analysis (CBA; Kohlenberg, Bolling, Kanter, & Parker, 2002; Kohlenberg, Tsai, & Dougher, 1993).

Every BT modality grounds the aetiology of healthy and unhealthy behaviour upon observable past experiences. Therapy involves offering opportunities for the person to learn new reactions to the same stimuli, and thereby change their behaviour. These hence corrective psychotherapeutic experiences would work through what behaviourists describe as operant and classical conditioning. Gathering proof of their individual effectiveness is critical (Skinner, 1987). For example, if someone flees upon the sight of dogs, due to having been bitten by a dog in the past, therapists might repeatedly expose that person to dogs that do not bite. To know therapy had been successful, the absence of fleeing would have to be observed.

Taking into account how the division of modalities across CBT waves is historical, and based on decades when some therapy was initially formulated, then, among first-wave CBT movements, there should be Albert Ellis' (1913-2007) rational psychotherapy (Ellis, 1958), which was, thereafter, named Rational-Emotive Therapy (RET; Ellis, 1962), and thereafter Rational Emotive Behaviour Therapy (REBT; Ellis, 1990). However, this is controversial. First of all, Hayes (2011), who was the first author to use the waves' approach, did not discuss REBT. Secondly, Herbert and Forman (2011) placed REBT in the second wave.

Finally, for Ellis, REBT was greatly influenced by existential and humanistic philosophies, and therefore should not be regarded as a CBT modality (Ellis, 2005a; 2005b; 1980). This justifies Hayes' omission of REBT from the list of CBT modalities. Simultaneously, Ellis also recognised that, against his will or desire, REBT was often made "*synonymous with*" (Ellis, 1980, p.325), "*similar to*" (Ellis, 2005a, p.154), or included under the CBT umbrella term. This justifies Herbert and Forman's (2011) option, but not quite in historical terms. Historically speaking, REBT started to be described in the literature in the late fifties, and, it being a 'CBT', it should thus be included in the first wave set of therapies.

Then, REBT is a modality which is sometimes classified as a CBT modality, principally more recently. It is also a modality where the influence of existentialism and phenomenology is rampant, and outwardly acknowledged by Ellis. Therefore, from the viewpoint of REBT, the clear-cut separation between existentialism, or phenomenology and CBT makes little sense. At least in REBT, these disciplines are intertwined. The inter-relationships between these disciplines can also be detected in other modalities, as it will be subsequently unpacked, but in less outward terms.

In the following section, and in part for its relevance for the present thesis, which is focused in the relationship between CBT and ET, REBT will be described in more detail.

1.4.2.1.1 Ellis' Rational Emotive Behaviour Therapy

Ellis' REBT accepted but actively modified BT's viewpoints and philosophy of praxis (Dryden, 2009; Ellis, 1958, 1980, 1990, 2005a, 2005b; Ellis & Bernard, 2006; Hyland & Boduszek, 2012). BT restricted its practice to behavioural, observable aspects. The use of

anything else was deemed unscientific. BT also anchored theoretically present behaviour on learnt behavioural contingencies and associations. Behavioural change could only be enacted by creating new behavioural contingencies and associations.

On the other hand, for Ellis, behaviour was important but so was subjectivity. Specifically, REBT:

> emphasizes that humans are born (as well as reared) as philosophers (Ellis, 1962, 1973a) and that they are natural scientists (Kelly, 1955), creators of meaning (Frankl, 1966), and users of rational means to predict the future (Friedman, 1975). One of its main goals, therefore, is to help clients make a profound philosophic change that will affect their future as well as their present emotions and behaviours (Ellis, 1980, p.326).

The discussion above illustrates the impact of existentialist-humanistic views on Ellis' work, among which Viktor Frankl's (1959, 2017) logotherapy can be found. It also shows how REBT differs greatly from BT in terms of philosophical assumptions, and practices. Unlike BT, REBT values and explores the influence of subjectivity on mental health. Under this framework, change is enacted by supporting 'philosophical change'.

Unpacking, according to REBT, people had the power to partly, though not totally, determine what happened to them in the present and in the future. They could do so by taking one of two main types of stands: a self-destructive, and a self-constructive philosophical attitude. Only by embracing the latter would mental health and well-being be fostered. As Ellis (1980, p.326) explained, everyone "*can actively choose to disturb or undisturb themselves (...), actively work at modifying their thoughts, feelings, and behaviours, (...) decide to profoundly change one's major philosophy*". Congruently, REBT aims at helping people to adopt constructive, rational

attitudes, and to make conscious and healthy choices about how to see their lives and circumstances.

Reiterating, for Ellis, as for most existentialists, people are autonomous beings. They do not have to act along what they were programmed for, by their genes and their environment. They can, to some extent, opt not to perform what they were programmed for. It is this power to choose, inclusively about how to make sense of "*their heredity and their environment*" (Ellis, 2005a, p.155), and so clearly discussed in Frankl's logotherapy, that is behind people's ability to self-determine their present and future lives and health.

The therapeutic process associated with REBT has been described by Dryden (2012) as the ABC process, where A stands for the internal or external activating event, B for the belief or systems of beliefs, and C for biopsychosocial consequences. That is, some event happens, either inside the person, or in the environment. Thereafter, one responds to the event by activating one belief, or systems of beliefs. Finally, at the end of the process, suffers the consequences of their response.

The beliefs referred to in the ABC process have been previously discussed as philosophical attitudes. More precisely, for Ellis (2005a, p.155), "*beliefs were not merely cognitive, but also included emotions and behaviours*". Said differently, beliefs are not necessarily well-elaborated philosophical perspectives, or logical, deliberate, conscious, mathematical, analytical, or explanatory decisions. Instead, beliefs can be fairly instinctive emotion-laden cognitive evaluations of stimuli. For instance, disliking someone one has just met for no apparent reason is also a 'belief' under REBT.

Then, Ellis concept of belief is close to concepts such as: "*hot cognitions*" (Hyland & Boduszek, 2012, p.108), which are emotion-laden automatic thoughts; António Damásio's 'feelings', which are a personal "*mental representation of the physiological changes that characterize emotions (...),*a *patterned collection of chemical and neural responses that are produced* ***automatically*** *[bold, in the original] by the brain when it detects the presence of an emotionally competent stimulus*" (Damásio, 2001, p.781).

A slight misunderstanding of Ellis' theory seems to have been partly fuelled by having overlooked this specific understanding of what beliefs amount to, and one which was likely aggravated by Ellis' use of the adjectives 'rational' and 'irrational' when discussing types of belief. Yet, as aforementioned, "*in REBT theory rational mainly means self-helping*" (Ellis, 1995, p.106). Having an irrational belief meant holding maladaptive responses i.e., self-destructive philosophical attitudes. Common irrational beliefs included "*unrealistic, illogical, absolutist, and devoutly held, even when they are unprovable and unfalsifiable*" (Ellis, 1995, p.106). These would represent innate tendencies, and "*were largely—not completely—correlated with*" people's emotional dysfunctions. For example, mental inflexibility, irrationality, and radicality are said to "*not always, of course; but quite frequently*" (Ellis, 2005a, p.158) result in mental illness, or at least in emotional distress (Bishop, 2000; Dryden, 2009; Rosner, 2011).

It is only now that it can be mentioned, without causing misunderstandings, how REBT focuses on addressing the irrational, unhealthy beliefs, which are commonly behind emotional dysfunctions (Dryden, 2005). Simultaneously, to boost mental health and well-being, it sought to foster constructive attitudes, including "*flexible preferences*" (Ellis, 2005a, p.155), "*self-interest, self-direction, tolerance of self and others, acceptance of uncertainty, flexibility,*

scientific thinking, risk-taking, and commitment to vital interests" (Ellis, 1980, p.137/338). Then, acceptance, of individual and environmental circumstances, and flexibility were to be fostered.

Despite the above clarifications, Ellis fled from deeming any particular attitude as unequivocally causing distress or, conversely, well-being. Instead, he offered every attribute as "*relative*" (Dryden, 2009, p.1) to circumstances and individuals as a whole. For example, the client might benefit from extreme beliefs in some particular circumstances, such as when rebelling against physical domestic abuse and needing to evaluate inflexibly such behaviour as undesirable in their personal circumstances.

Ellis further advocated that there was a complex and dynamic link between behaviour, emotions, and belief systems (Ellis, 1995; 1980). These aspects were intimately intertwined. As remarked, "*emotions are not merely feeling states but also include important cognitive and behaviour aspects; and that behaviours are not merely actions but also include thinking and emotional factors*" (Ellis, 2005a, p.155). Change to any of these aspects was expected to potentially have long-term, cascade effects at every level.

Said differently, "*human disturbances do not merely follow from (or are 'caused' by) Irrational Beliefs (IBs) but follow from a combination of dysfunctional thoughts, feelings, and behaviours. Yes, all three working integrally together*" (Ellis, 2005a, p.155). Clients, by "*profoundly changing one major philosophy, they may help modify many of their own emotional and behavioural reactions*" (Ellis, 1980, p.326).

Technically speaking, the desired outcome of REBT is to motivate clients to achieve the key goals that they have set for themselves (Joseph & Chapman, 2013). Although REBT takes an

active-direct approach (Ellis, 2005a), the methods through which therapists help clients to achieve such a desired outcome is not rigidly described. For example, the therapist might invoke humour, be formal or informal, use metaphors and stories, and so on. The therapist can also disclose personal information as a way of building a rapport (Dryden, 2009). Humour targets emotions, but it can also help to dissolve an extreme cognitive belief and help to build a more acceptant philosophical perspective of the self and the world instead (Dryden, 2009).

Additionally, the therapeutic relationship is valued by Ellis in a way that echoes existentialist, humanistic, and client-centred approaches. In face-to-face arrangements, therapists are to "*unconditionally"* (Ellis, 1980, p.327) accept clients, their idiosyncrasies, and their potential. An effective REBT therapist is thus described as one with a degree of flexibility, varying their approach and choice of techniques to meet the needs of the client at each stage in their relationship (Dryden, 2009).

From the standpoint of current practices, REBT is practised as an inelegant form of therapy, more concerned with the practical issues of helping to reduce dysfunctionality and less with philosophical change (Dryden, 2009), and thereby closer to CBT modalities that emerged subsequently. Achieving philosophical change is elegant REBT practice.

Overall, REBT views individuals as "*holistic*, *goal-directed*" (Ellis, 1980, p.327), and empowered with the ability to change what happens to them. To do so, they must embrace constructive attitudes and change destructive attitudes. These changes are expected to have cascade, long-term effects at emotional, cognitive and behavioural levels, and benefit mental health and well-being.

1.4.2.2 Second-wave CBT

Second-wave CBT modalities emerged during the 1960s and the 1970s (Hayes, 2011; Herbert & Forman, 2011). Unlike BT, and like Ellis, second-wave modalities place great emphasis on information processing models (Carvalho, Martins, Almeida, & Silva, 2017), and the impact of cognition on mental health. This is so much so that this period is also sometimes coined "*cognitive revolution*" (Knapp & Beck, 2008, p.55; Lorenzo-Luaces, Keefe, & DeRubeis, 2016, p.785; Beck, 2005, p.953), and was greatly boosted by psychiatrists such as Aaron Beck, and developmental psychologists such as Jean Piaget and Albert Bandura (Beck & Haigh, 2014; Hayes, 2004). Given the centrality of Beck's CT for the definition of current CBT practices, this second-wave modality will be detailed in the following section.

1.4.2.2.1 Beck's Cognitive Therapy

Aaron Beck, mostly known for the initial development of Cognitive Therapy (CT), outwardly acknowledged the influence from Ellis' REBT on CT (Beck, 2005). This acknowledgement supports the decision of having included REBT in the first-wave CBT group.

In these early beginnings, CT sought to contribute to the treatment of depressive disorders (Beck, 1961, 1991, 2005), as diagnosed through a purpose-built paper-and-pencil survey. It was subsequently expanded to the treatment of "*anxiety disorders and phobias, panic disorder, followed by personality disorders, and substance abuse (…). More recently, this approach was used to clarify the psychological structure and CT of schizophrenia*" (Beck, 2005, p.953). Thus, CT is clearly a diagnosis-oriented modality that was developed condition-by-condition and delineates condition-specific clinical interventions which target the symptoms that

'quantitatively' characterise them at a cognitive, 'information-processing' level. As Beck succinctly described:

> CT treatment is goal-oriented, time-sensitive, educative, and collaborative, and it is based on an information processing model. The cognitive model posits that the way people perceive their experiences influences their emotional, behavioral, and physiological reactions. Correcting misperceptions and modifying unhelpful thinking and behaviour brings about improved reactions (Beck, 1991, p.368).

Negative Automatic Thoughts (NATs) are a type of dysfunctional thinking pattern. They are thoughts that are habitual and triggered automatically in response to an event (Hofmann et al., 2012; Longmore & Worrell, 2007), and which are revealing of mental inflexibility, rigid generalisations and dichotomies of great vs. catastrophic, and the overvaluing of negative or detrimental aspects (Weishaar, 2001). Yet, Beck limits his theory and practice to the cognitive realm. Unlike Ellis, who posited that what was sometimes deemed pathological was not an illogical cognitive evaluation of some stimulus, but actually maladaptive biopsychosocial evaluations.

The manifestation of NATs include clients labelling themselves as 'losers' when failing a test, or concluding that they are unloved or disliked because someone forgot their birthday (Beck, 1976). The repetition of NATs in many situations would suggest that these had rigidified into core beliefs (Wenzel, 2012). These core beliefs belonged to the information processing structure named 'schemas'. Schemas are psychic structures which determine "*how phenomena are perceived and conceptualized*" (c.f. Clark & Beck, 1999, p.79, Wenzel, 2012, p.18), and their content consists of core beliefs and NATs.

NATs, principally when ‘solidified’ as core beliefs and integrated into schemas, are said to affect behaviour (Fenn & Byrne, 2013). For example, if clients often think they are losers, they may start to exhibit avoidance behaviours aimed at not performing any activity where failure is possible (Dozois & Beck, 2008). NATs and core beliefs also affect emotional states; clients can become distressed by the thought that they are losers, or feel at ease by avoiding situations where failure is impossible. NATs are often the preferential target of CBT therapists because they are thought to be more accessible and very situationally circumscribed, and, as such, easier to change (Glasman & Albarracín, 2006).

The goal of interventions is to instil flexibility into one’s thoughts, creating a gap between the events, the NATs, the cognitions these engender, and the feelings that follow their emergence (Beck, 2011). Therapists seek to achieve this purpose by actively: pinning down the clients’ interpretation of events while they talk (Beck, 2011); asking questions; classifying cognitions in terms of psychopathology, thought patterns and reasoning processes; confronting distorted and irrational thinking (Wentzel, 2013); and providing clients with a set of psychological tools that can be used to think a situation through.

For instance, the advantages and disadvantages of an event can be listed, or the thoughts, feelings, sensations, and behaviours experienced after a particular incident can be discriminated. These tools are often conveyed under the form of homework and are expected to help clients plan and strategise their reactions to certain events (Wright, 2006). At some point, their use should progressively induce mental flexibility and eliminate the NAT, possibly by replacing it with a healthier thought (Wright, 2006).

As implicit to the above descriptions, Beck was greatly concerned with diagnosis-oriented evidence-based theory and practice (Beck, 2005; Edwards, 1990). His studies addressed the "*reliable and valid*" (Beck, 1961, p.61), or "*consistent and adequate*" (Beck, 1961, p.53) measurement of the symptoms disorders, and how CT could minimize or resolve these symptoms. The aim was to to establish, systematically, and as scientifically as possible, how specific psychiatric disorders can be described in terms of questionnaire-assessed "*maladaptive cognitions"* (Hofmann et al., 2012, p.428), irrational and dysfunctional thoughts and emotions (Beck, 2011; Beck, 2005; Williams & Garland, 2002a), and distress-triggering 'faulty information processing' (Beck, 1976, 2011; Longmore & Worrell, 2007; Weishaar, 2001). It is these psychiatric 'symptoms,' at the core of specific disorders, that therapists are expected to seek to minimize or resolve using pre-defined techniques during face-to-face sessions (Joseph, 2016; NIMH, 2016; Wentzel, 2013).

The importance assigned to empirical research by CT brings Skinner's intents to mind, the difference being that Beck, unlike Skinner, viewed the study of subjectivity as scientific as the study of behaviour. Yet, CT does not offer answers to BT's philosophical criticism (Skinner, 1987) regarding the use measures of subjectivity in research. Of the modalities revised thus far, only Ellis' REBT does so, by assuming from the beginning that emotions, thoughts, and behaviours are a single (albeit multifaceted) entity, and, as such, it is senseless to speak of behaviour as an objective, isolated aspect.

Additionally, Beck assigned to surveys a value of behavioural truth. Opinions were behavioural manifestations, and surveys measured, for example, "*the behavioral manifestations of depression*" (Beck, 1961, p.61). Yet, answering 'I take care of sleep hygiene', an indication of mental health, does not necessarily mean that one actually does it (e.g. social desirability biases,

or "*the basic human tendency to present oneself in the best light possible*"; Fisher, 1993, p.303). The link between opinion and behaviour may not only be complex, as mutable, as acknowledged by Ellis.

Similarly unlike REBT, CT does not give great importance to the link between behaviour, cognition, and emotions, or to the therapeutic relationship. At a later stage of modality development, Beck recommended that therapists pay attention to the aspects of alliance (Gebler & Maercker, 2014), countertransference (Prasko et al., 2010), and "*transference reactions*" (Ottens & Hanna, 1998, p.314) for specific diagnosis of personality disorders. In more recent adaptations of CT, the value of the therapeutic alliance was elevated in importance to the status of a therapeutic tool to use for purposes such as modelling new 'parental schemas' (Ottens & Hanna, 1998, p.314). Yet, the importance of these relationships is merely a satellite; it is not at the core of CT's theory, philosophical perspective, or practices.

Furthermore, CT is often referred to as CBT in the literature (Beck, 2005). What many people understand CBT to be is actually the merging of CT and BT. Given that Knapp and Beck (2008) refused to recognise a common theoretical foundation underlying CT (second-wave), BT (first-wave), and CBT, this merging is likely not, from Beck's own viewpoint, a theoretical form of integration. Instead, it is, at best, a form of technical eclecticism, for both BT and CT are oriented towards evidence-based practices.

1.4.2.3 Third-wave CBT

This far, BT and REBT were identified as first-wave CBT modalities. It was also clarified that REBT embraced BT's presumptions, and expanded them to the value of attitudes, which cover

the interconnection of behaviour, emotions and cognitions. Thereafter, CT was described as a second-wave CBT modally, with notable theoretical and practical differences to both REBT and BT. Namely, in the primacy assigned to surveys to the measurement of disorders and treatment outcomes, it valued cognitions above all other aspects.

Finally, there are third-wave CBT modalities, which are those developed from the 1990s onward. For Hayes (2004, p.644), their emergence was possible with *"the rise of constructivism and similar postmodernist (and post-postmodernist) theories*". Their development aimed at increasing the effectiveness of first and second wave therapies, by emphasising contextual and experiential strategies to enact beneficial change (Carvalho, Martins, Almeida, & Silva, 2017). Despite these common roots:

> no one factor unites these new methods, but all have ventured into areas traditionally reserved for the less empirical wings of clinical intervention and analysis, emphasizing such issues as acceptance, mindfulness, cognitive defusion, dialectics, values, spirituality, and relationship (Hayes, 2004, p.640).

Above, Hayes suggested that third-wave CBT modalities share their openness to unorthodox, less investigated areas, and their belief that hermeneutic interpretations *necessarily* shape experience. Said differently, objectivity is impossible to achieve. Regarding researchers, and therapists, their individuality would shape the meanings of what was observed, measured, and concluded. As for study participants or clients, their individuality would also shape what was experienced, reported, done, and so forth. In both cases, reality was being constructed by its observer.

For example, a punch could be as much a sign of affection as a sign of aggression; it was intrinsically neither. Its meaning derived instead from the activity of thinking observers or interacting subjects. Hence, for these modalities, classifying the 'objective' nature of the observable gesture for empirical testing would be as fallacious as the study of subjective emotions and cognitions was for Skinner. Consequently, their therapeutic practice may involve changing the clients' attitude or understanding of events that had been classically understood as objective up until then (e.g., Hickes & Mirea, 2012) and becomes more similar to the practices employed in alternative modalities, including ETs (Hickes & Mirea, 2012).

Despite Hayes' description above, not every third wave modality is concerned with meaning-making in its hermeneutic sense. For instance, Teasdale and colleagues' Mindfulness-Based Cognitive Therapy (MBCT; Hayes, 2004; Teasdale et al., 2003; Teasdale, 1999) focuses on potentiating moment-to-moment self-awareness of cognitions, emotions, and behaviours, as opposed to actively producing changes in modes of functioning (Segal, Teasdale, Williams, & Gemar, 2002). This modality proposed, with empirical support, that there was no need to change cognitions directly for beneficial changes to occur (Hayes, 2004). It is thus not quite concerned with intervening at the level of meaning-making and much less on changing these sensations and 'felt meanings' towards rationality and hermeneutics; rather it helps people to detect what they are experiencing.

Additionally, there are several approaches, emerged during the 1990s, that rested close to Skinner's classical assumptions, including Functional Analytic Psychotherapy (FAP; Kohlenberg, Hayes, & Tsai, 1993; Kohlenberg & Tsai, 1994; Kohlenberg, Tsai, &

Kanter, 2009). FAP seeks to "*produce change through the natural and curative contingencies of reinforcement that occur within a close, emotional, and involving therapist-client relationship*" (Kohlenberg et al., 2009, p.841). Under FAP, behavioural contingencies (vs. interpretations) are critical.

One of the aspects that sets FAP apart from BT, as originally conceived by Skinner, is the way relational context is valued. By claiming that "*special opportunities for therapeutic change (…) occur when the client's daily life problems are manifested within the therapeutic relationship*" (Kohlenberg et al., 2009, p.842), FAP gets closer instead to the psychoanalytic concept of transference and to Rogers' perspective on the value of the therapeutic relationship.

Yet, as noted by Hayes, several third-wave modalities are fundamentally concerned with hermeneutics. One is Dialectical Behaviour Therapy (DBT; Hayes, 2004). It seeks to integrate Zen Buddhism teachings into CBT, and, as the name suggests, emphasises the importance of dialogue, collaboration, and dialectical thinking. It was initially developed to support suicidal individuals and then used in a more general sense to treat clients with borderline personality disorder who tended to have suicidal thoughts (Crane, 2008; NIMH online, 2016; Zayfert & Becker, 2008).

Another third-wave approach is Hayes and colleagues' Acceptance and Commitment Therapy (ACT; Hayes, 2004; Hayes, Follette, & Linehan, 2011; Hayes & Hofmann, 2018; Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Kohlenberg et al., 1993). ACT focuses on changing ongoing thinking patterns and action intentions by developing psychological flexibility and instigating the acceptance of the "*function and meaning*"

(Hayes, 2004, p.647) of contextualised psychological events, so as to thereafter allow clients to choose and commit to specific change goals and values (Hayes, 2004).

Many, if not all, third-wave approaches, and even CT as it evolved through time (Ottens & Hanna, 1998), recognised the importance of the therapeutic relationship. As Perris (2000) postulated, more recent CBT modalities, which he classified as 'second generation' (as opposed to third wave), could also be distinguished precisely by the importance assigned to the therapeutic relationship, which had been generally disregarded by BT and CT alike. FAP is a clear-cut example. In addition to this, greater emphasis is placed on the bidirectionality of the relationships between aspects of human experience, echoing an idea which had already been proposed by Ellis' REBT. ACT and its focus on the relationship between individuals and their context is an example of this.

In sum, a variety of third wave modalities has been developed since the 90s. These include: ACT, which focuses on accepting personal experiences and values and acting out pre-defined goals; MBCT, which focuses on awareness of the moment-to-moment flow of experiencing; DBT, which involves questioning and counter-questioning experiences; and FAP, which emphasises therapeutic relationships as echoes of the regular life of clients.

1.4.3 Limitations of CBT

The discussion of first, second, and third wave modalities, above, sought to illustrate how the label CBT has been utilised to describe a wide diversity of theories, each of which with distinctive sets of practices. As an umbrella term, it even covers modalities with clashing assumptions, such as BT and CT. As noted, the views of these modalities are the conflicting,

particularly in regards to the value and use of measures of subjectivity for boosting mental health and behavioural change. Whereas BT dismisses measures of subjectivity such as attitude surveys, as not scientific, CT built its approach around their use.

In the literature, the label 'CBT' tends to disregard, without discussion, the heterogeneity mentioned above, and be used to refer to what apparently is a general, single, homogeneous, evidence-based, institutionally recommended modality. In the following section, evidence concerned to support this recommendation is reviewed, as related to the efficacy of 'CBT', or of one particular CBT in particular, for the treatment of specific disorders. It will follow a discussion of found long-term benefits, and raised criticism limiting the value of CBT/ CBTs.

1.4.3.1 CBTs' Condition-Specific Efficacy

CBT, as currently practised in institutional settings, seeks to resolve clients' psychiatric symptomatology, as it is identified through clinical interviewing or surveys (e.g. Beck's depression inventory; Beck, 1961). These symptoms, used to specific the psychiatry diagnosis presented by the client, in the eyes of the clinician, are generally established by psychiatric manuals, like the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Their causes, and the treatment of these causes, tend to not be valued by CBT-as-CT. Better said, aetiological factors are not as critical for CT, as for: BT, which simply presumes that pathological symptoms result from the client's learning history; for Sigmund Freud, for whom infancy trauma was the origin of pathology; or for psychopharmacology, which seeks to address aetiological chemical imbalances pharmacologically.

Studies investigating the efficacy of 'CBT' in addressing specific psychiatric diagnoses and their symptoms are here referred to as 'condition-specific efficacy' studies. Qualitative and quantitative meta-analyses of these studies abound. For instance, Cuijpers, Berking, Andersson, et al. (2013) discovered 115 RCTs of the efficacy of 'CBT', as compared to other treatments, control groups or psychopharmacology, for treating depressive disorders. They further identified 42 past meta-analyses about the same topic. Since then, 2013, the number of RCTs and meta-analyses has surely increased.

This to say that, although studies about the efficacy of the treatment of depressive disorders are particularly proliferous, in part for the high incidence of the disorder, and the ancie t history of its treatment via CBT, disorders other than those from the depressive spectrum have also originated an impressive amount of testing. Understandably, condition-specific RCTs and their meta-analytic study will not be thoroughly reviewed here. Instead, this review will circumscribe itself to addressing evidence diverging from, and limitations to the mainstream claim that CT is effective at reducing symptoms and relapse rates for a wide variety of conditions, as put forward inclusively by CT's founder, Beck (2005).

Condition-specific efficacy investigations often concluded that CBT was unequally effective across different types of psychiatric disorders (Jauhar et al., 2014; Lynch, Laws, & McKenna, 2010). Reported effect sizes varied from large to small. This means that CBT is not infallible; large is different from 100% and small is very different from 100%. Other modalities have also been found to be unevenly effective. Furthermore, for some conditions more than others, the effectiveness of CBT was comparable to that of other therapies. This means that CBT is as infallible as some alternative modalities for the treatment of these disorders.

For example, Butler, Chapman, Forman, and Beck (2006) reviewed the effect sizes of 16 'methodically rigorous meta-analyses' concerned with the efficacy of CBT-as-CT per psychiatric diagnosis, across a wide variety of control groups and modalities. Reported effect sizes were large for several disorders within the unipolar depression and anxiety spectrum. But, its efficacy was comparable to that of BT in addressing specifically depressive and obsessive-compulsive disorders.

Hofmann et al. (2012) reviewed 106 meta-analyses examining the efficacy of CBT in a variety of disorders. Unlike Butler et al.'s (2006) findings, depressive disorders were not among those with the highest effect sizes. Instead, 'CBT' had a medium effect size for the treatment of depressive disorders. It was also as effective as psychodynamic treatments, problem-solving therapy, and interpersonal psychotherapy. According to Tolin (2010), when depressive and anxiety disorders showed comorbidity, CBT was found to be superior to psychodynamic therapy at both post-treatment and at six months follow-up. Furthermore, David, Szentagotai, Lupu, and Cosman (2008) compared REBT and CT for the treatment of depression and found that each modality had comparable effect sizes.

Reviewing, for the case of depressive disorders, the efficacy of CBT-as-CT or of 'CBT' was found to be comparable to CBT-as-BT (Butler et al., 2006), CBT-as-REBT (David, Szentagotai, Lupu, & Cosman, 2008), and to a multitude of more clearly not CBT-related therapies, such as brief dynamic psychotherapy (Hofmann et al., 2012; Linde et al., 2015). Exception registered for the case of comorbidity with anxiety disorders (Tolin, 2010). This states of affairs evoques the aforementioned equivalence paradox, discussed at the beginning of this chapter, and raises doubts about the preference assigned to CBT by the British NHS and Beck's (2005) conclusion.

Even across studies sharing the same CBT-as-CT conceptualisation, Beck's (2005) conclusion, and the mainstream recommendation, is put to question. Namely, Parker et al.'s (2003, p.826) in-depth inspection of the efficacy of CBT-as-CT, for the particular case of depressive disorders, gathered at different stages of depression, led them to conclude that "*in terms of superiority to other manualized psychotherapies or to basic clinical management, we suggest that the verdict of the efficacy of cognitive behaviour therapy as not proven holds.*"

A similar state of affairs is observed when discussing other distinctive clinical diagnoses, focusing on other modalities and using diverse outcome measures. Research often suggests that the effects of distinctive therapies are either equivalent (Cuijpers et al., 2013; Paley et al., 2008; Stefan et al., 2019; Stiles, Hill, & Elliott, 2015; Stiles, Barkham, Mellor-Clark, & Connell, 2008), or non-consistently superior or inferior, even under very specific circumstances (Cuijpers et al., 2013; Reid, 1997; Tolin, 2010). Butler et al. (2006) found that CBT-as-CT had moderate effect sizes for treating marital distress, anger, childhood somatic disorders, and chronic pain. This means that CBT-as-CT was not so frequently effective for dealing with these pathologies. In a study by Hofmann et al. (2012), effect sizes for some of these disorders were, in fact, large, specifically for somatoform disorders and anger control problems.

Finally, in a meta-analysis of 70 studies examining the temporal changes in the effects of CBT, Johnsen and Friborg (2015) illustrated that the effects of CBT declined linearly and steadily over time. The decline in treatment effects was attributed to therapists not following the manual and properly implementing CBT. As Crits-Christoph et al. (1991) and Luborsky et al. (1985, 1997) found, therapists who frequently depart from the manual demonstrate poorer treatment effects than therapists who follow the manual. This demonstrates the importance of therapeutic

alliance and therapist competence as well as a standardised treatment process in the implementation of CBT.

In conclusion, evidence of the superior efficacy of 'CBT', including CBT-as-CT, CT-as-BT, and CBT-as-REBT, for specific diagnoses is not consistent across studies, for none of the inspected conditions. In many cases, CBT and CBTs show comparable efficacy to other modalities, including psychodynamic or interpersonal therapy. As such, its comparative efficacy of is still open for debate.

1.4.3.2 Long-term Benefits of CBT

The gathering of convergent evidence, about CBTs condition-specific efficacy, is hindered by the heterogeneity of the label. Nevertheless, post-treatment effect sizes are less frequently or less strongly observed at follow-ups up to a decade after the intervention, as compared to immediate short-term treatment measures (David et al., 2008; Freeman & Garety, 2004; Hofmann et al., 2012; Lemmen et al., 2015; Paykel, 2007; Szentagotai & David, 2010).

Secondly, the magnitude of the beneficial effects of CT or CBT has been found in some studies to be inferior to that of REBT. David et al. (2008) investigated the efficacy of REBT, CBT, and pharmacotherapy in the treatment of outpatients with nonpsychotic major depressive disorder. They found that REBT was significantly better than CT and pharmacotherapy at 6 months follow-up. In addition to this, Lemmens et al. (2015) compared CT and interpersonal psychotherapy for the treatment of major depressive disorder, but neither treatment was superior at post-treatment, and at five months follow-up. Similarly, Ashman et al. (2014) found that CBT was not more effective in treating depression than supportive psychotherapy.

Moreover, Starck (2008) explored three specific case studies of individuals undergoing CBT treatment. She observed that two (out of three) of the participants in her study "s*ubsequently sought further treatment within a different modality*" (Starck, 2008, p.500). For these two participants, CBT had been "*a useful, valuable modality but one which, by its very nature, only required short-term, time-limited utilisation, and only helped within a circumscribed area of mental health*" (Starck, 2008, p.500). She thereby suggested that CBT lacked long-lasting and generalisable efficacy. Thus, both qualitative and quantitative studies have raised questions regarding the long-lasting nature of the therapeutic effects of CBT.

In summary, the long-lasting nature of the therapeutic effects of CBT has been questioned (Hofmann et al., 2012; Starck, 2008; Szentagotai & David, 2010) and seems to be apparently lower than that found at post-treatment (David et al., 2008; Lemmen et al., 2015; Paykel, 2007; Szentagotai & David, 2010). To solve this apparent lack of durability of the effects of CBT, Szentagotai and David (2010) suggested that new CBT treatments targeting long-term outcomes should be developed from within CBT modalities. Karwoski, Garratt, and Illardi (2006) further proposed the development of integrative modalities. Yet, given the inconsistent pattern of superiority and inferiority registered for distinctive modalities in terms of a wide variety of situations, including the type of disorder, conclusions should be made with caution. It can only be offered that the lasting effects of CBT, cannot be ascertained and lacks convergent evidence.

1.4.3.3 General Criticism to CBT

In addition to the limitations posed by the evidence reviewed in preceding sections, 'CBT', most often equated with CT, has been extensively criticised. Specifically, it has been raised criticism about CBT's methodological specifications, for their said-to-be excessively mechanist and directive orientations, eventually even to the point of disrespecting clients' experience and volition (Gaudiano, 2008; Freeman & Garety, 2004; Rhodes & Jakes, 2009). As an example, spiritually inclined clients will not find in CBT ample grounds for having spiritual meaning-making discussions (Gebler & Maercker, 2014; Prasko et al., 2012; Zoellner & Maercker, 2006). Some clients may even feel overpowered, passive, and not responsible for their treatment at all (Kotler & Shepard, 2008; Ringle et al., 2015). This is very much so even when clients' engagement and active role in their treatment has been described as beneficial (Royal College of Psychiatrists, 2009).

In addition to this, there is a simplification of clinical diagnoses (Seligman, 1995); and a disregard for differences in the severity of the pathology (Parker, Roy, & Eyers, 2003; Scott, 2011). The structured nature of CBT means that therapists also have a tendency to address the clients' initial plaint to the exclusion of any other (Freeman & Garety, 2004); the therapist often only focuses on very specific issues and do not address the possible underlying causes of mental health conditions such as childhood trauma (NHS Choices, 2010). Moreover, CBT does not consider the clients' gender, coping skills, age, and ethnicity (Crews & Harrison, 1995; Gabbard & Ogden, 2009; Seligman, 1995). Thus, its "*problem-oriented strategies are not enough*" (Gebler & Maercker, 2014, p.156), and argued to be useless in certain cases (Gaudiano, 2008; Rhodes & Jakes, 2009; Zettle & Hayes, 1987).

Finally, research regarding the theoretical underpinnings of CBT, and particularly of CT, is scarce and disappointing. Namely, CT's claims about the psychotherapeutic benefits of changing distorted cognitions have failed to be experimentally demonstrated (Gaudiano, 2008; Parker et al., 2003; Zettle & Hayes, 1987). Furthermore, studies suggest that NATs seem to be equally reduced by REBT, ACT, and CT alike (Stefan, Cristea, Szentagotai, Tatar, & David, 2019). Moreover, some have suggested that intervening at an emotional level is apparently and empirically more important than intervening at a cognitive level (Kotler & Shepard, 2008; Parker, Roy, & Eyers, 2003; Teasdale et al., 2001; Teasdale, 1999), or that behavioural interventions often suffice (Gaudiano, 2008). Eventually, "*no additive benefit to providing cognitive interventions in cognitive therapy*" is found (Zettle & Hayes, 1987 p942). Kotler, and Shepard (2008) highlight that human beings are multi-faceted, with feelings as well as thoughts. It is suggested that CBT puts undue emphasis on thought processes to the exclusion of many legitimate feelings, thereby contributing to repression and the denial of feeling.

These aspects above are just some of the contentions raised toward the study and clinical use of a modality that is often referred to in general terms, as 'CBT', and covers a wide range of technically eclectic practices, from BT to ACT. As with the use of the general label, the field may be have a criticisable tendency to simplify excessively many aspects of therapy, from the diagnosis, to the process, or the value of the clients' needs and desires.

1.4.4 Overview of the Value of CBT

Overall, findings reviewed under these sections raise questions about the preferential utilisation of CBT. Efficacy studies have been criticised, principally when involving poorly defined or greatly heterogeneous variables (e.g. CBT-as-CT and CBT-as-REBT-and-CT), and thereby

failing to clarify univocally which modality is best, if any. Efficacy studies, and their possibly controversial value, further suggest that CBT is not always efficacious; it is less efficacious in the long-term; and it is at best equally as efficacious as other approaches in condition-specific situations, lacking convergent validity of its efficacy.

Some studies did target independent variables that appear to be less heterogeneous than CBT, and thereby provide results that are potentially more trustworthy. For example, mindfulness tools, which increase self-awareness of ongoing, present experiences, are part of the strategies of ACT and MDBT and tend to be operationalised rather homogeneously.

Evidence suggests that mindfulness training is effective for lowering distress, depression, and anxiety (Kumar, Feldman, & Hayes, 2008; Roeser et al., 2013; Stafford-Brown & Pakenham, 2012), enhancing cognitive performance such as working memory, self-efficacy, and rumination (Kumar et al., 2008; Roeser et al., 2013; Slagter et al., 2007; Stafford-Brown & Pakenham, 2012; Zeidan, Johnson, Diamond, David, & Goolkasian, 2010); as well as enhancing general health (Christopher et al., 2011; Zeidan et al., 2010). Yet, as with alternative apparently beneficial psychotherapeutic mechanisms proposed in the literature, such as the flexibilisation of cognitions and beliefs (Paykel, 2007), mindfulness is not a tool employed exclusively by CBT modalities. It is not even a tool utilised by more classical CT and BT-oriented approaches.

In addition to this, the application of CBT has been heavily criticised for its structuredness. The rigid CBT process means that the therapy is very present centred and dismisses new symptoms and thoughts. The intervention also does not address other issues that may have a huge impact on the client such as family and social factors. Thus, the standardised nature of

CBT and the reliance on the competence of the therapist can actually hinder the beneficial effects of CBT and its associated modalities. Similar reasoning led some authors to propose new CBT application processes, such as Rhodes and Jakes' (2009) non-directive, non-confrontational and non-therapists-centred therapy.

1.5 The Value of ETs

As CBT, ET has been described as an umbrella terms, covering many different modalities (Edwards, 1990; Cooper, 2003, 2017; Correia et al., 2018; Halling & Nill, 1995; Hoffman, Dias, & Soholm, 2012). These are thus here sometimes referred to in the plural: CBTs and ETs. Although both CBTs and ETs, when taken as a single category, then have a diversity of founding 'fathers', most of their sub-modalities can be easily traced back to one or two key psychologists or psychiatrists. Skinner and Beck figure amongst the most prominent founding fathers of sub-modalities of CBTs.

Nonetheless, unlike CBTs, which sometimes show diametrically opposing beliefs, such as BTs and CTs regarding the value of subjectivity, most ETS hold similar philosophical tenets (Gebler & Maercker, 2014). This is so much so that Spinelli (2006a) remarked that:

> *rather than being a particular technique or method of therapy, existential psychotherapy more than anything else provides therapists with a set of foundational principles that serve as guidelines and 'meaning structures' which underpin their practice* (Spinelli, 2006a, p.311).

That is, what is critical and remarkably characteristic across ETs is their philosophical assumptions, many of which derived from phenomenology. This philosophy branch has been

described as "*first-person science of consciousness*" (Smith, 2013, p.xi). Yet, as the discipline matured, it became interested in aspects other than those accessible to consciousness. Namely, it also embraced, early on, the investigation of pre-reflective, embodied, relational, intentional, and situated lived experiences (Spinelli, 2006a; 2006b). Moreover, it sets out to "*study subjectivity objectively and objectivity subjectively*" (Deurzen, 2014, p.54). Thus, it questions the objectivity of Skinner's 'objective' and measurable reality, by arguing that the meanings assigned by the observer and the actor to any observable, measurable event are partly subjective.

The phenomenologists more commonly recognised to have influenced ETs are Edmund Husserl, the founder of phenomenology (Hickes & Mirea, 2012; Laverty, 2003; Schacht, 1972; Smith, 2013), Martin Heidegger (Barua, 2007; Cohn, 1997; Dreyfus, 1993; 1975), and Jean-Paul Sartre (Dreyfus & Wrathall, 2009; Elveton, 2007; Howells, 1992; Wrathall, 2009). But, according to Wrathall (2009), none of these phenomenologists utilised the term existentialism to refer to their own work. Instead, the term was first used in a 'mistranslation' from French to English of the title of a book, by Jean-Paul Sartre, originally named 'La Transcendence de L'Ego: Ésquisse d'une Description Phénoménologique'. In this translation, the term 'phenomenological' became 'existentialist' (Elveton, 2007).

Thereafter, the term existentialism spread wide, through English speaking communities, most popular in the United States of America. It referred to a French philosophical and literary movement, to which Sartre, Maurice Merleau-Ponty and Albert Camus, among others, supposedly belonged (Wrathall, 2009, p.31). Sartre himself ended up describing his work as "*existential psychoanalysis*" soon after the translation episode (Stern, 1958, p.38).

One of the implications of the above discussion is that the term existentialism, when not understood as synonymous with phenomenology, lacks strong epistemological foundations. It is even described as an "*oddly shaped philosophical movement dubbed "existentialism" by its ultimate (and perhaps only) full-time practitioner, Jean-Paul Sartre*" (Solomon, 1992, p.597) This lack of definition might even have led Mosak and Maniacci (2005, p.74) to propose that "*existential psychology is not a school but a viewpoint.*"

Secondly, the three philosophers identified above can be described adequately as, more than existentialists, phenomenologists in method and interests (Wrathall, 2009). Their philosophical thought and writings influenced to varying extents one or another ET. Finally, the way Sartre, Merleau-Ponty and Camus valued, conceptualised, and inspected two core aspects of aims of phenomenology, namely, understanding people's ontology and ontics, "*is very different indeed*" (Schacht, 1972, p.294).

Under a Husserlian approach, ontology is a discipline interested in identifying the 'universal' and abstract attributes that characterise the existence of every being. These characteristics are sometimes referred to as 'existential givens', and were unpacked by as 'modes of being', or "*that on the basis of which beings are understood*" (Dreyfus & Wrathall, 2005, p.3). An example is accepting that 'all beings are mortal', and that such mortality is an universal attribute of humanity (Cohn, 1997). On the other hand, ontics consists of the set of idiopathic, as opposed to universal attributes that characterise a specific person or object. That is, to "*the properties or the physical relations and structures peculiar to some entity*" (Dreyfus & Wrathall, 2005, p.3). For instance, 'John died yesterday' would be one, of the many ontic attributes of John.

Philosophers and psychotherapists who claim to follow phenomenology, and/or existentialism resolve questions of ontology and ontics with varying degrees of systematic ordering, logic, and aims. In the following sections, an effort to trace down authors' main differences and similitudes will be made. Yet, it must be recognized at the outset that these authors sometimes employ convoluted discourses, and have been subjected to multiple competing interpretations (Dreyfus & Wrathall, 2005; Howells, 1992; Smith, 2013).

Moreover, presently, the term existentialism is more often used to refer to psychotherapeutic, as opposed to philosophical frameworks. The opposite is true for the term phenomenology. As Spinelli (2006b, p.2) recognised, "*there exists a coherent and cohesive inter-relation between the enterprise of phenomenological enquiry and the enterprise of psychotherapy as understood from an existential perspective.*" Hence, albeit the differences in valence of these terms, the three terms, psychotherapy, existentialism, and phenomenology, point towards a similar objective: better understanding human beings and their lived experiences.

In the following sections, four ETs will be detailed: Ludwig Binswanger's Daseinsanalysis; Viktor Frankl's logotherapy; Irvin Yalom's ET; and Emmy van Deurzen's Structural Existential Analysis. Finally, efficacy considerations will be offered as a starting point for the establishment of a relationship between CBT and ET and the possibility of their integration.

1.5.1 Existentialist Therapies

'Existentialism' and phenomenology are philosophical theories that propelled the development of several distinctive ETs. Recently, attempts have been made to clarify that which unites and separates these ETs (Cooper, 2003/2017; Correia et al., 2018; Correia, Cooper, & Berdondini, 2015; Spinelli, 2006a; Spinelli, 2006b; Stumm, 2005).

Shared attributes include an interest in the "*human lived experience*" (Cooper, 2003/2017, p.1) or existence, and particularly the ontic "*actual personal experience of clients*" (Correia et al., 2018, p.4) while they go about their living. ETs assume that every person is unique in their experiences and are consequently "*sceptical and averse to any attempts to standardize theory or practice*" (Correia et al., 2015, p.3; Hickes & Mirea, 2012). This is so even when their authors refer to ontological, universal aspects of human experience (Cohn, 1997), for ETs tend to conceptualise these ontological aspects in their relation to that person's unique ontics.

ETs simultaneously accept the "'*structuredness' of any experience*" (Spinelli, 2006b, p.2) and its variation person-by-person, moment-by-moment, and so forth. ETs deal with client ontics in their practices, not with ontology per se. Congruent with this position, ETs tend to adopt phenomenological inquiry methods (Spinelli, 2006b), rather than standardised diagnostic tools as only these methods would be capable of revealing each person's unique subjectivity. They further embrace "*the questionable value of psychotherapeutic analyses which are predicated upon natural scientific, modernist assumptions and accordingly fashioned by the dictates of a logico-empiricist methodology*" (Spinelli, 2006b, p.1) among which CBT can be found. Based on either undue generalisations of human subjective empirical experience or one of the many possible interpretations of that person's ontics (Boss, 1963). In a way, this means that many ETs simultaneously accept and reject every scientific (or pseudoscientific) observer systematisation of mental health and mental health treatment (Boss, 1963). This led Norcross (1987, p.52) and Ghaemi (2001) to conclude that existentialism and phenomenology conceptually allowed for the "*integration*" of every theory.

Moreover, most ETs offer the interrelatedness or interdependency of experiences as a prime reason for valuing the uniqueness of subjectivity (Spinelli 2006a, 2006b). This relational aspect

is extended, more or less extensively and explicitly, to each person's past, present, and future and situated "*ecological systems*" (Bronfenbrenner, 1994, p.37) to which such a person belongs. ETs tend to see every phenomenon, be it a memory, a belief, a sensation, an interpersonal relationship, or a therapeutic effect, as relational. For instance, a memory only comes to mind in certain environmental and bodily contexts and times. One might recall things differently when facing someone else, in a different mood, or after different daily events. Consequentially, most ETs seek to inspect the way clients relate to their world and themselves so that they can freely choose their attitude toward objects encountered, and thereby change their experience and mental health (Spinelli, 2006b).

In sum, ETs tend to share four main attributes: an interest in the individual lived experience; the use of phenomenological methods (and reservations about objective measurement methods); the interdependent nature of experience; and the ability to change one's 'relational attitude'.

Cooper and colleagues discriminated (Cooper, 2003, 2017; Correia et al., 2018) four types of ETs: Ludwig Binswanger's 'daseinsanalysis'; life purpose and "*meaning-centered*" (Cooper, 2003, 2017, p.xiii) ETs; the 'North-American' "*cross-fertilization*" (Cooper, 2003, 2017, p.xii) between humanistic and existentialist modalities, to which Yalom and Bugental supposedly belong; and existential-phenomenological ETs. This distinction is somewhat problematic. Firstly, alternative grouping strategies have been put forward (e.g., Edwards, 1990). Hence, rationally opting for theirs would involve a clear preference for their choice, which, as it will soon be explained, is not the case.

Secondly, the description of each one of these four branches, as provided by Cooper and colleagues, seem to be motivated mainly by geographical reasons, above and beyond any other

theoretical and practical consideration. For example, Emmy van Deurzen's (2016) approach was included in the European existential-phenomenological modalities category. Its focus would rest on "*the client's relation to their world (interworldly)*" (Correia et al., 2018, p.4). This focus on the intrapsychic is precisely how Krug (2009) described the focus of the humanist Bugental, Frankl's 'meaning-centred' logotherapy and Binswanger's daseinsanalysis that in Cooper and colleagues' classification do not belong to the North European branch.

Similarly, the valuing of the moment-to-moment being-in-the-world of clients within the consultation room (i.e. 'presence'; Krug, 2009; Stumm, 2005) and the therapeutic relationship is associated by Cooper (2003, 2017) with the humanistic-existential modalities. If valuing the therapeutic relationship is the single inclusion criterion, which apparently it was, then other author modalities from other categories should also be included in this very same category. For example, the more 'European' (Cooper, 2003, 2017; Correia et al., 2018) daseinsanalysis, under Boss' formulation, pays close attention to the clients' presence and the therapeutic relationship (or Martin Buber's 'I-Thou-encounter'; Boss, 1963; Cohn, 1997). This interest is offered as a logical necessity of the application of Heidegger's later writings to psychotherapy.

That is, most, if not every ET values the therapeutic relationship. For Spinelli (2006b), this is indeed one of the attributes uniting every ET. Yet, it is also an attribute characteristic of modalities classically regarded as humanistic, but not necessarily existentialist, such as Carl Rogers' client-centred therapy, in which the therapeutic relationship is a necessary and sufficient condition for successful therapies (Rogers, 1957/2007). That is, valuing the relationship cannot possibly be the single criterion for classifying an approach as 'North-American' existential-humanistic, as Correia and colleagues did - and if it was, then one would probably end up including in the ETs branch every humanistic approach, as Edwards (1990)

did. Yet, even CBT began valuing the therapeutic alliance at some point (e.g., Edward, 1990; Ottens & Hanna, 1998).

For this reason, ET classification systems will be disregarded here. Instead, the following sections will describe succinctly some of the most commonly used ET author modalities, giving but a flavour of their diversity.

1.4.1.1 Ludwig Binswanger's Daseinsanalysis

Daseinsanalysis (the analysis of 'being-there'; Cohn, 1997) is a philosophical, not a scientific, approach to therapy greatly influenced by the early writings of Heidegger (Boss, 1963; Cohn, 1997; Cooper, 2003, 2017; Frie, 2010;). It stands against Freud's "*naturalism*" (Cohn, 1997, p.4) or the idea that beings can be fully described in terms of biological mechanisms. It was founded by the psychiatrist Ludwig Binswanger (1881-1966) and expanded to the investigation of therapeutic practices by one of his most well-known disciples, Medard Boss (1903-1990). Both entertained a relationship with Heidegger and tried to apply his theories to mental health treatment, albeit in different ways (Cohn, 1997). Binswanger is said to have been influenced by Heidegger's earlier, more ontology-oriented writings, and sought to make phenomenological and ontological descriptions of psychotic states. Boss, on the other hand, is said to have been influenced more by Heidegger's later, interrelatedness-oriented writings; he had greater clinical experience of neuroses and sought to inspect therapeutic clinical practice (Cohn, 1997; Fried, 2010; Norcross, 1987).

Binswanger was also greatly influenced by Husserl's writings, and attempted to describe the existential structures (world designs) behind 'normal', as described by Heidegger in 'Being

and Time', and abnormal functioning, as encountered in clinical practice (Ghaemi, 2001; Norcross, 1987). He argued that normal and abnormal world designs were innate existential structures, and, in such a sense, "*a priori and transcendental*" (Cohn, 1997, p.17). These could be described phenomenologically, from the viewpoint of clients and without referring to any specific "*overarching theory*" (Ghaemi, 2001, p.52). Overall, he offered "*subtle and often profound descriptions of a client's world*" (Cohen, 1997, p.6), focusing greatly on intrapsychic dynamics. As explained by Ghaemi (2001, p.54):

> *it is these differences in existential structure which underlie the most primary differences of mental illness; everything else (symptoms and signs, biological responses, psychosocial aspects) follows from and is secondary to the changes in existential structure* (Ghaemi, 2001, p.54).

For Binswanger, psychology and psychiatry should, first and foremost, seek to understand how a person relates to objects (other people, situations, objects, existential conditions, etc.) from the perspective of clients themselves. Phenomenological description methods were utilised to "*delineate the 'pretheoretical' nature of the being of Dasein*" (Ghaemi, 2001, p.53), that is, mental illness from the stance of the mentally ill.

Although daseinanalysis is the ET framework that is sometimes described as being interested in pathology the most (Cooper, 2003, 2017), this is mainly due to the contributions of Binswanger. Boss valued less innate and pathological world designs. Both Heidegger and Boss criticised Binswanger for having disregarded the interrelatedness and situational aspects of ontic issues, namely, for neglecting the thereof Being in his analysis of Dasein, or existence (Cohn, 1997). He was also criticised for neglecting the way each individual dealt with their ontological characteristics (e.g. own mortality). He discussed instead a mid-term between ontic

and ontological existential issues; his innately determined, pathology-inducing 'world designs' or existential structures.

Boss avoided the use of Binswanger's term 'world designs', and focused more attentively on the degree of openness or narrowness of clients to the 'world of possibilities' and 'all things encountered'. Narrowness would be associated with pathology, and openness to well-being (Cohn, 1997). Boss further detailed more extensively daily, clinical, and relational psychotherapeutic practices (Boss, 1963; Cohn, 1997), for which description he turned to Heidegger's later writings about being-in-the-world and Buber's discussions of the I-thou relationship. Boss saw therapy as a situated and intersubjective enterprise, where the relationship between the therapist and client both contributed to the shape of that person's being-in-the-world (Boss, 1963). In a way, Boss' daseinsanalysis retained the interest of psychoanalysis in transference (Boss, 1963). Within this approach, transference, along with any other relational issue occurring within the consultation room, was to be explored and valued for relating to real-time client issues (Boss, 1963; Flajoliet, 2010).

1.5.1.2 Viktor Frankl's Logotherapy

Viktor Frankl (1905-1997) coined his psychotherapeutic approach logotherapy, as in the therapy of 'logos', which in ancient Greek stands for reason, word, or "*meaning*" (Frankl, 1959, 2017, p.102). Logotherapy is generally regarded as an ET, justly classified as a life purpose and "*meaning-centered*" existentialist modality by Cooper and colleagues (Cooper, 2003, 2017, p.xiii; Correia et al., 2018). Indeed, it is theoretically and practically concerned with what Frankl regarded as a simultaneously 'ontological' and 'ontic' human drive, coined "w*ill to meaning*" (Frankl, 1959, 2017, p.103). In its foundational and "*indispensable*" (Frankl, 1956,

2017, p.105) ontological character, it could be compared to Nietzsche and Adler's 'will to power' and to Freud's 'will to pleasure'. For Frankl, it even supplanted the will to pleasure in importance: "*man's main concern is not to gain pleasure or avoid pain but rather to see a meaning in his life*" (Frankl, 1956, 2017, p.112).

For Frankl, the search for meaning would thus be "*a primary motivational force (...) and not a 'secondary rationalization' of instinctual drives (...) and can be fulfilled by him alone*" (Frankl, 1956, 2017, p.103). Such ontological drive would only realise itself at the ontic level of the personal lived experience. It would further create an inner state of tension, versus an inner state of equilibrium or "*homeostasis*" (Frankl, 1956, 2017, p.105) that would underpin mental health and well-being. Specifically, the absence of such a tension (the need to find meaning), or of an idiopathic circumstantial purpose, would, in Frankl's opinion, trigger an "*existential vacuum*" (Frankl, 1956, 2017, p.105), active "*suicide*" attempts (Frankl, 1956, 2017, p.107), "*mental and physical decay*" (Frankl, 1956, 2017, p.77), "*depression, aggression, addiction*" (Frankl, 1956, 2017, p.107). Individuals would cease to look forward to the future and, more or less rapidly, and more or less passively, destroy their lives - as "*if he had already died*" (Frankl, 1956, 2017, p.74). It is rather remarkable that this psychotherapeutic modality was used to help those in situations of great distress, and inclusively by him with his Auschwitz's fellow prisoners.

In brief, logotherapeutic techniques actively incite individuals to find, or better said, 'choose' what propels them to action, that is, their life purpose or "*a future goal to which he could look forward*" (Frankl, 1956, 2017, p.76) by looking at the meanings held by whatever condition and situation they find themselves in. This helps clients to sustain a healthy state of inner

tension and shapes their 'identity' and future: "*the more one forgets himself - by giving himself to a cause (...) - the more human he is*" (Frankl, 1956, 2017, p.109).

A chosen meaning or goal is not a passive, frozen representational box. It is rather a context-sensitive, forward-looking, action-propelling choice that affects present and future events by inducing "*self-actualization*" (Frankl, 1956, 2017, p.109). By choosing a specific meaningful attitude, individuals are said to be able to self-determine, self-actualise, or personally influence what happens to them in the present and future. This possibility is discussed by Frankl in ways that echo Heidegger's understanding of being-in-the-world:

> *a human being is not one thing among others; things determine each other, but man is ultimately self-determining. What he becomes - within the limits of endowment and environment - he has made out of himself*. (Frankl, 1956, 2017, p.123).

Thus, one must determine the meaning of the situation and the direction one seeks to take. As Frankl (1956, 2017, p.80) put it, "*it did not really matter what we expected from life, but rather what life expected from us*". This can be achieved by looking at Heidegger's 'there-of-being' (Cohn, 1997), the intersection between all things existing at a given moment and place.
The importance assigned to this forward-looking and context-sensitive attitude is what clearly sets logotherapy apart from other psychotherapeutic modalities. Most alternative modalities at the time had been mostly concerned with the clients' past, or a traumatic situation they had encountered, from Freud's inspection of infancy traumas to Skinner's history of contingencies. Psychotherapeutic alternatives also tended to be individualistic, anchored on the well-being of the individual in isolation, as a being that was not permanently influencing and being influenced by overall circumstances. Logotherapy asks clients to look instead to their surroundings and find their meaning there rather than within their "*own psyche*" (1956, 2017,

p.109). It thereby allows clients to become "*fully aware of his own responsibilities*" (1956, 2017, p.108), toward others and themselves, including "*the responsibility of judging*" (1956, 2017, p.108) the meaning of situations.

Secondly, Frankl reinforced the importance of opting for a humanistic attitude. Since each person could decide how to give meaning to situations and act accordingly, then each person would have the responsibility to show "*high moral behaviour*" (Frankl, 1956, 2017, p.70), and do the 'right' thing, changing the world and oneself for the better *"if possible (...) and necessary"* (Frankl, 1956, 2017, p.120). Frankl actually recognised another major influence behind the development of logotherapy, the work of phenomenologist Max Scheler, who extensively discussed ethics and how people related and should relate to one another (Cooper, 2003, 2017; Frankl, 1956, 2017). Yet, Frankl's interest in intersubjectivity and ethics limited itself to the relationships established by clients outside therapy, and their social behaviours. These should be scrutinised in a search for meaning and purpose. Then, Frankl "*does not place a strong emphasis on the therapeutic relationship and will encourage clients to find meaning for their lives from an intersubjective perspective*" (Correia et al., 2018, p.4), where 'intersubjective perspective' should be read specifically as relating to the way each person behaves socially toward other people outside the consultation room.

In sum, logotherapy assumes that seeking the meaning of life, critically and specifically, of one's own life (Cooper, 2003, 2017; Frankl, 1956, 2017) is a basic need that allows each individual to sustain a healthy state of mind, make more meaningful choices, find a purpose, actively combat the meaninglessness or nothingness of their lives, and self-determine their future.

1.5.1.3 Irvin Yalom's ET

Irvin Yalom (1931 - to date) developed an ET that involves dealing with clients' lived experience or ontics of existential, ontological concerns (Yalom, 1980). Among these concerns, one finds some of those discussed by Heidegger and Sartre, such as death, freedom, isolation, and meaninglessness (Berry-Smith, 2012; Krug, 2009; Yalom, 1980). These were to be approached from the unique view and experience of each client, and systematically, contemplating their psychological (i.e. empirical), humanist (i.e. value-laden) and philosophical (i.e. theoretical) characteristics (Allan & Shearer, 2012; Gardner, 1999). For Yalom, empowering clients to discuss these concerns in therapy would help them to achieve greater well-being.

Ontics is at the centre of Yalom's approach. Standardisation of treatment processes seems unnecessary and useless. For example, Bond, Bloch, and Yalom (1979) conducted an observational study about the opinions of patients, therapists, and independent judges and the improvements registered in regard to a 'target problem' and other areas. They found little agreement and specificity between the three evaluating groups ratings for both the target problem and other areas. For Yalom, every therapeutic decision should be based on the uniqueness of each client. Such uniqueness revealed itself in the way clients viewed their overall structural or 'essential' (Krug, 2009) conditions, in an Heiggerian and logotherapeutic sense, and Heidegger and Sartre's ontological issues (Berry-Smith, 2012).

In Yalom's ET, as with logotherapy and daseinsanalysis, there is an intrapsychic focus. Yet, as with Boss' daseinsanalysis, the "*presence*" (Krug, 2009, p.330) and the here-and-now being-in-the-world of clients within the consultation room is fundamental (and needless to say more fundamental than 'ratings'). It helps in "*illuminating the client's underlying subjective*

constructs of self and world" (Krug, 2009, p.331). Although attention to presence does not necessarily imply anything other than an observational stance on the behalf of therapists, it is assumed than only an empathic therapist can do so 'atheoretically'. When presence is discussed under ETs, it is normally relating to Buber's I-thou considerations, which suggest that someone's uniqueness can only be detected when an empathic relationship is formed.

May and Yalom (1989) discussed the importance of an existential perspective within a CBT or REBT environment. They argued that, in order to fully address existential issues, therapists must "*confront the client directly and firmly*" (May & Yalom, 1989, p.362). This stance is not widely accepted by alternative ETs, where, congruent with phenomenological inquiry methods, they virtually all demand presence, but not necessarily confrontation.

1.5.1.4 Emmy van Deurzen's Structural Existential Analysis

Emmy van Deurzen (1951-to date) developed a systematic ET coined Structural Existential Analysis (SEA), which was greatly influenced by the phenomenological writings of Husserl, Heidegger, and Buber (Deurzen, 2002, 2014, 2016). In line with Husserl's proposal, she takes it as a method rival with statistical analysis, which is Beck's method of choice. Under SEA, therapy must be seen as a journey of philosophical importance (Steffen & Hanley, 2014), which requires clients to immerse themselves in their "*sensory experience and become reflective about your affective life*" (Deurzen, 2014, p.54). In this explanation, one can detect echoes of mindfulness techniques and Ellis' REBT.

Deurzen was central throughout this thesis due to the comprehensive way she embraces phenomenological assumptions and the Husserlian and rigorous character of her technical approach to therapy. Specifically, according to Deurzen (2014), therapists should take into

consideration, six critical phenomenological aspects. First, there are the three aspects of Husserlian intentionality, namely, the object, the intentional object, and the intentional link, that is, the relational act bringing the object into the consciousness of subjects, from a memory to a sensation.

Secondly, there is the "*dialogical and hermeneutic*" (Deurzen, 2014, p.56) form of interviewing, that is founded on therapists' empathic skills, in Bubber, Boss and Yalom's sense, that helps to understand clients' experiences. Thirdly, there is the therapists' ability to work with their own bias, "*recognising it, locating it at all times and learning to suspend it temporarily when necessary and possible*" (Deurzen, p.2014, p.59). Fourthly, therapists are to approach clients' four interlinked worldly spheres, dimensions or "*relational layers*" (Deurzen, 2014, p.61), namely, the physical, the personal, the social, and the spiritual, as well as their tensions, conflicts, and paradoxes. Fifthly, there are Heidegger's timelines, which are the past, present, and future. Finally, there are "*the emotional movement and the compass*" (Deurzen, 2014, p.56), which depict the affective and critical intentional act through which people relate to the world and "*value or fear*" (Deurzen, 2014, p.64) it.

In brief, therapists and researchers should explore these six aspects systematically, so as to come to grips with the unique meanings of intentional objects for each client; their ontics. For instance, the death of a spouse may raise physical difficulties (e.g. the deceased person was taller and tall enough to reach the higher kitchen cabinets), personal (e.g. sadness and longing), social (e.g. the deceased person joined the client in every event) and spiritual (e.g. the client struggles with the fairness of such death). Some of these illustrative difficulties are directed to the past (e.g. longing), to the present (e.g. difficulties reaching high cabinets), and some to the future (e.g. envisaging going to social events alone). All these aspects further help to describe

the (emotional) value of the deceased person for the client. As Deurzen notes, "*the focus is therefore on life itself, rather than on one's personality. The aim is to assist people in developing and consolidating their personal way of thinking*" (Deurzen, 2002, p. 18), as it relates to a wide variety of aspects.

Note that these guidelines are not guidelines in the sense employed by CBT as professed in many practices and mental health services, such as the NHS, which specifies aspects such as treatment duration, diagnoses, and condition-specific treatment plans. Rather, these work as loose recommendations about what could be tackled during the therapeutic process. Secondly, the issues experienced by each client are always unique and idiopathic and maybe experienced solemnly in relation to one aspect, rather than all.

For Deurzen, SEA would help clients to deal (rather than resolve or eliminate) more expertly with past, present, and forthcoming life issues, possibly in a manner alike Dreyfus' (2002) skilful coping. This requires therapists "*to help people to live in time, past, present and future in equal measure*" (Deurzen, 2008, p. 150). Thus, whereas Frankl (1956, 2017) is interested in the future, Deurzen seeks to balance the importance assigned to each time frame.

In addition to this, SEA seeks to foster the development of coping skills and as such the effects of SEA are expected to endure. By focusing on one's existence as an autonomous and rational being, individuals would be further enabled to engage in relationships and interactions with themselves, others, and the world more authentically, passionately, and truthfully (Deurzen, 2009). Under Deurzen and Adams' (2016) understanding, and unlike Sartre, the only factors restricting the freedom of individuals are gender, race, culture, family members, and genetic

make-up. Besides these restraints, individuals would generally be free, and their identities formed in light of the choices they made and their consequences (Deurzen & Adams, 2016).

1.5.2 The Efficacy of ETs

In comparison to CBTs, and despite greater recent efforts, the efficacy of ETs has not been extensively investigated, and especially through meta-analyses and RCT studies (Cooper, 2003, 2017; Gabbard & Ogden, 2009; Gebler & Maercker, 2014; Hickes & Mirea, 2012; Vehling & Philipp, 2018). There is even, in the area, as discussed, a certain 'resistance' to evidence-based paradigms, which prioritize the ontology, or generalizable traits, over the ontics of clients (Hickes & Mirea, 2012; Hoffman, Dias, & Soholm, 2012; Spinelli, 2006b; Correia et al., 2015). Yet, this resistance is not quite aligned with the philosophical assumptions behind ETs. It would be more consistent to look at every explanation, including statistical methods, "*in its spirit of 'not knowing' (…), and thorough mutual and open exploration of 'all that it is'* (Hickes & Mirea, 2012, p.20).

ETs further tend to disregard abstractions of lived experience beyond ontological structures (e.g. Deurzen's four worldly spheres or Yalom's existential concerns), or those derived from phenomenological reductions (e.g. Binswanger's world-designs), and even these must be situated in the experience of someone or something in particular. As Frankl shared, the ontological (and thus, 'cross-individual', 'common', 'normal' or 'universal') "*meaning of life differs from man to man, from day to day and from hour to hour. What matters, therefore, is not the meaning of life in general but rather the specific meaning of a person's life at a given moment*" (Frankl, 1959, 2017, p.107). Then, despite the search for 'universal' attributes,

existential therapists remain more interested in understanding how each individual client experiences and deals with their issues.

ETs apply this reasoning to any therapeutic aspect, including psychiatric diagnoses, around which CBT's empirical research and practice revolve (Dryden, 2009; Spinelli, 2006a). As Prochaska and Norcross (2009, p.116) put it, "*the existential therapist will attempt to weigh in with an honest and authentic opinion, but trying to control a freedom-enhancing psychotherapy would be antithetical to its purpose*". Thus, ETs value more individualised approaches to treatment, and may even oppose their standardisation.

Despite these reservations, recommendations for increasing their empirical nature have been made (Hickes & Mirea, 2012), and some meta-analyses (Bauereiß, Obermaier, Özünal, & Baumeister, 2018; Park et al., 2019) and single studies (Breitbart et al, 2010; Lee, Cohen, Edgar, Laizner, & Gagnon, 2006; Vehling & Philipp, 2018; Vos, 2016; Vos, Craig, & Cooper, 2015) about the efficacy of ET interventions have been conducted. Empirical studies suggest that many patients, such as those with life-threatening diseases, including cancer patients and survivors, suffer from existential concerns, lack meaning and purpose, and benefit from approaches that address these issues (Breitbart et al, 2010; Bauereiß et al., 2018; Vehling & Philipp, 2018; Vos, 2016).

Another area deserving some considerate attention in ETs, but not in CBTs, refers to the acceptance, and active adaptation of the therapeutic process to the clients' religious and spiritual values. Specifically, Captari, Hook, Hoyt, et al., (2018) detected 97 outcome studies assessing the impact of shaping therapy to clients' beliefs, as compared to no-treatment controls, alternate standard treatments, and additive standard treatments. They found that

standard and/or spirituality-oriented treatments were equally effective at reducing psychological distress, but only spirituality-oriented treatments enhanced spiritual well-being.

Despite Captari, Hook, Hoyt, et al.'s, (2018) thorough meta-analysis, not many can be found in the literature. One of the reasons for this lack, proposed in the literature, is the diversity of operationalized definitions of ETs, and targeted outcomes (Bauereiß et al., 2018; Vos, Craig, & Cooper, 2015). In Bauereiß et al.'s (2018) meta-analysis, ETs were those which were "*manualized and addressed existential needs as a main component, for example by creating meaning, fostering hope or dignity, or by supporting patients in expressing their feelings and fears towards the end of life*" (p.3532). This operationalized definition allowed them to select 24 studies, comparing the value of ETs for adult cancer patients to randomized control groups, assessing benefits in diverse moments in time. They found that ETs enhanced self-efficacy, existential well-being and quality of life, at post-treatment, and feelings of hope at post-treatment and after six months. No significant effects were found for spiritual well-being, depression, or anxiety at either assessment point.

On their part, Park et al. (2019) conducted a meta-analysis comprising 29 outcome studies, with cancer patients, focused on meaning and purpose, as compared 'psychosocial interventions.' Although both types were effective for enhancing meaning and purpose in cancer patients at post-treatment, 'meaning/purpose interventions' showed high and superior effects on overall health, with an effect size comparable to interventions designed specifically to reduce symptoms of depression, pain, and fatigue.

Overall, found meta-analytical investigations showed great heterogeneity, in terms of results, outcome measures, and operationalized definitions of ETs. Most meta-analyses further

generally disregarded the main and differentiating assumptions set forth by the founding fathers of specific ETs. Nevertheless, some single studies embracing author-congruent approaches have been conducted. Namely, Breitbart and colleagues (Breitbart et al., 2010; Breitbart, Gibson, Poppito, & Berg, 2004) developed a logotherapy-inspired, eight sessions-long group intervention revolving around meaning. Their RCT compared its effects to a similarly eight sessions-long supportive group intervention (Breitbart et al., 2010), concerned with social and psychological coping skills. Findings suggested that the supportive group intervention had null significant results on spiritual well-being, meaning, hopelessness, desire for death, optimism/pessimism, anxiety, depression, and overall quality of life. Conversely, their logotherapy-inspired intervention led to significant improvements in spiritual well-being and meaning. It also decreased patients' anxiety, hopelessness, and desire for death (but not their depression). These improvements were also observed at a follow-up assessment two months later.

Despite the heterogeneity noted above, studies conducted inspecting meaning-focused interventions tend to point towards their beneficial effects. Even if, in ETs, condition-related outcome measures are somehow antithetical to the purpose of ET, trustworthy evidence is lacking, and assessment processes potentially faulty, authors' clinical experience has been argued to have reinforced their belief in the helpfulness of their ET, inclusively with bereaved populations (Bond et al., 1979; Yalom & Lieberman, 1991).

In sum, high-quality empirical evidence associated with ETs is generally much less extensive than that gathered for CBTs. This hinders their recommendation by health institutions, such as the NHS, and health organisations, such as the DSM, which are reassured by 'scientific-proof-of-worth'. Nevertheless, some evidence supporting the including of aspects of meaning,

purpose, and spirituality in the treatment process has been found for diverse measures (e.g., overall health, spiritual well-being, self-efficacy, and hope). There are also a couple of studies suggesting the effects of meaning interventions might endure (Bauereiß et al., 2018; Breitbart et al., 2010; Vos, Craig, & Cooper, 2015), though never as compared to the outcomes of CBTs.

1.6 Combining ETs and CBTs

As explored in previous sections, the practices and theories of the sub-modalities of CBT vary widely, and probably more widely than those of ET. Many studies, and principally empirical studies about the efficacy of CBT, fail to acknowledge this diversity. This lack of attention sometimes leaves the impression of being presented, inductive or deductive, but otherwise potentially crude generalizations about each type of therapy. Some of these claims even run the risk of being deemed false, from the viewpoint of one or another sub-modality. In the present thesis, an effort was made to refrain from ignoring this diversity, such as through the use of the quite explicit labels ‘ETs’ or ‘CBTs’, which use the plural.

The richness and interest of the discussion of the integration of ETs and CBTs is heightened by the heterogeneity mentioned above. These aspects are also heightened by the absence of exhaustive integration-orienting guidelines, in the manners of assimilative integration strategies. As discussed in the introduction, this lack makes this field quite promising, at the level of the variety of personal experiences and clinical decision-making.

In the following sections, some of the more evident philosophical tensions between these modalities are detailed. These struggles are concerned with the way modalities value, in different, eventually even opposing manners, subjectivity, objectivity, and meaning-making.

Throughout this discussion, whenever possible, it will be indicated which sub-modalities most clearly illustrate, or have reflected upon the conflict. Integration-oriented clinicians are potentially aware, and afflicted by these contrasts.

It will follow an historical review the integration of CBTs, and particularly REBT and CT, and ETs, or existentialism and phenomenology, as philosophical disciplines, since their origins. Thereafter, a more extensive discussion will be held in regards to third-wave modalities, most of which are integrative, to a great extent. These last two sections intend to illustrate how some phenomenological tenets have long been incorporated into CBTs. This is so much so that, when speaking about their integration, one should better say the aim was incorporating 'more' phenomenological assumptions and/or existentialist practices into one or another form of CBT. Subsequently, it will be reviewed a couple of new modalities and intervention programs, which seek to integrate more extensively, at theoretical and/or practical levels, respectively, ETs and CBTs. Empirical results of their efficacy will also be offered. At the end, some concluding reflective remarks are included.

1.6.1 Objectivity and CBTs

Both ETs and CBTs have been criticised for their mental health treatment strategies. Namely, ETs have been condemned for their excessive focus on subjectivity, and CBTs for their excessive focus on objectivity. Yet, this orientation towards apparently antithetical values is one of the main defining attributes of these therapeutic modalities, as generally understood. Namely, as discussed previously, the mains founders of BT and CT sought actively to develop objective, standardised and scientifically corroborated theories, and, especially practices (Gaudiano, 2008; Hofmann et al., 2012; Paley et al., 2008; Williams & Garland, 2002a). For

diagnosis, clinical decision-making, efficacy assessments, and theory development, preference is given, and inclusive by third-wave modalities, to statistical and experimental methods (Mason & Hargreaves, 2001).

Therapists are instructed to choose treatments in accordance with clients' cognitive, behavioural, and emotional symptoms, most of which identified by the DSM-5. These symptoms are to be detected during the first few sessions, through surveys or standardised structured interviews (Rhodes & Jakes, 2009). This recommendation is not surprising. These methods of diagnosis easily lend themselves to statistical analyses. The underlying assumption is that clients' disorders can be objectively described, have a fixed, long-term, 'material' and/or measurable character, and can be treated via empirically sound, standardised, and short-term approaches. Therapeutic success is predicated on symptom remission or reduction. Under CT, it is claimed that illness can be measured and treated by changing measurable cognitions (Ellis, 2005a; Hyland & Boduszek, 2012), whereas, under BT, illness can be measured and treated by changing measurable behaviours (Skinner, 1987).

In summary, sub-modalities of CBT tend to offer highly structured, norm-oriented treatments since their original development. During these treatments, inter-individual differences are, until proven otherwise, regarded as irrelevant and statistically insignificant. Comprehensive or whole person individual patterns, or, for that matter, any other aspect beyond the set of measured and diagnostically significant symptoms, tend to be disregarded (Edwards, 1990; Gaudiano, 2008; Gebler & Maercker, 2014; Freeman & Garety, 2004; Rhodes & Jakes, 2009; Zettle & Hayes, 1987). Unsurprisingly, CBTs have been criticised for their inability to deal with individual differences, or to treat effectively presentations which differ from the norm (Bennett-Levy & Lee, 2014; Creed, 2014, Dudgeon & Kelly, 2014; Edwards, 1990; Freeman

& Garety, 2004; Gaudiano, 2008; Gebler, & Maercker, 2014; Hickes & Mirea, 2012; Johnsen & Friborg, 2015; Norcross & Hill, 2004; Rhodes & Jakes, 2009; Zettle & Hayes, 1987).

In addition to this, CBTs have been recognized to disregard the treatment of the causes of the clients' problems. Only current problems and specific issues, identified at the beginning of the therapeutic process, are addressed. There is even perhaps a slight confusion between the cause/aetiology, the cause/reason, and the consequence/ symptom of a disorder; "*the cause and the reason (…) in some cases get mixed up in CBT (…). 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*" (Ameli, 2016, p.214).

Said differently, the medical paradigm urges the use of the term cause, or aetiology, to refer to an objective, and biological cause of the abnormal state of an organism. Say, high levels of testosterone are associated with deficient self-control of aggressive impulses (Kaldewaij et al., 2019). High testosterone was thus a likely cause of the high aggressive tendencies of some particular person. However, it is rather unlikely that the aggressive person, or their social environment, will identify testosterone as a reason for acting. It is much more likely they recognize instead they were for example wronged, or angry. And in this way, the cause and reason for acting can confused with one another, and result in poor treatment efficacy and absence of comprehensive and long-lasting success (Freeman & Garety, 2004).

1.6.2 Subjectivity and ETs

On the other hand, ETs have been criticised for being excessively subjective (Mischel, 2004). Empirical support for theories and clinical decision-making is lacking (Cooper, 2003, 2017;

Gabbard & Ogden, 2009; Vehling & Philipp, 2018). Standardised treatments, relevant for consistency of practice, are generally absent (Edwards, 1990; Hyland & Boduszek, 2012). Instead, treatment strategies opt for basing clinical decision-making on qualities of the here-and-now relationship between therapists and clients. This is understandable as ETs value clients' ontics, and their comprehensive, whole person, ever-changing patterns of functioning. Better said, ETs do "*recognize a criterion of objectivity*" (Edwards, 1990, p.109), when comparing experiences to one another, but the attention is on individual, temporal and situational differences and changes. It is not on well-established symptoms of disorders, detected for that person, at some specific point in time, through statistical, majority-based methods.

There are even existentialists for whom establishing objective symptoms, diagnoses and standardized treatments is a flawed, "*superficial*" (Ottens & Hanna, 1998, p.313) endeavour. Therapists should eventually even "*forget about cautious objectivity*" (Deurzen, 2014, p.58), for it attributes weight to a perspective of the self that is not as 'whole', mutable, and dynamic, as the phenomenological conception of the self is (Dryden, 2009; Massey, 2015). Thus, when crafting disorder-specific 'world designs' or exploring structural or ontological aspects, existentialist therapists fully embrace their own and clients' subjectivity (Edwards, 1990). Diagnoses, treatments, and theories fall upon dialetic (against survey-based), qualitative (rather than quantitative), phenomenological (rather than statistical) methods (Spinelli, 2006a), and target precisely what those keen on objectivity undervalue: the uniqueness of experiences.

Above all, the role of the phenomenological existentialist therapist is not to find a 'cure' for symptoms-as-problems (Spinelli, 2006a), or to correct clients' Beck's 'erroneous perceptions' (Edwards, 1990). Rather, it is to help clients to discover the present and/or future meaning of

their lives to equip them for more authentic and adaptive choices (Deurzen, 2009; Deurzen & Adams, 2016; Frankl, 1956, 2017; Spinelli, 2006a), and to sustain a healthy level of 'angst' (i.e. anguish or existential anxiety; Deurzen, 2009; Frankl, 1956, 2017; Yalom, 1980; Spinelli, 2006a). As Ameli and Dattilio (2013, p.309) put it, "*one cannot always control his or her anxiety level, but can choose*" whether to get distressed by it. To enable this choice, the client needs to be honest and provide full details of their experiences and the paradoxes they engendered (Deurzen & Adams, 2016).

Then, whereas CBTs seek to achieve symptom remission, successful ET interventions have been predicated on clients' obtaining autonomy, meaning, 'self-realisation', 'integration', deeper understanding of their strengths and weaknesses, confronting their ultimate concerns, and so forth (Deurzen, 2009; Ryan, Lynch, Vansteenkiste, & Deci, 2011; Schneider & Krug, 2010; Yalom, 1980). These are to be achieved by tapping into clients' relational subjectivity. This is in part because ETs (and REBT, which sits mid-way ETs and CBTs) view "*existence as relational*" (Ottens & Hanna, 1998, p.315), where relational should read in a Husserlian sense, as in constant relationship with an intentional object.

As Özünal and Baumeister (2018, p.2532) posited, "*physical, psychological, and spiritual well-being seem to be connected*" elements, and co-contribute, in ways that are difficult to discriminate from one another, to the way clients experience existential (e.g. end-of-life distress, and sense of purpose), practical (e.g. coping), cognitive (e.g. self-efficacy perceptions), physical (e.g. pain), and emotional (e.g. level of despair, depression and anxiety) issues. This 'intentional/relational' view of the world is generally extended by ETs to the importance of relationships that occur outside (Deurzen, 2009; Frankl, 1956, 2017) and inside the consultation room (Boss, 1963; Flajoliet, 2010; Krug, 2009).

That is, ET therapists, when consistent with the philosophical tenets of their modality, must accept that meanings can only be looked at from a 'relational', contextualised, time-bound, and subjective microscaled perspective. Since there are "*general time-limited or temporal constraints upon our intentional 'meaning-making'*" (Spinelli, 2006a, p.311), the 'palpability' of reality is only 'palpable' for an intentional perceiver in a specific point in time and space. Thus, with some exceptions (Yalom & May, 1989), ETs tend to argue that therapists' understanding of clients' issues must be revealed in a narrative manner, that requires time and patience (Schneider & May, 1995). This long discovery of the troubles of the person must precede any more interceptive therapeutic choice (Spinelli, 2006a).

Unlike wise, as stated, CBTs tend to view meanings as rather fixed, immutable, and set in stone. This belief allows the establishment of clients' difficulties in the first treatment sessions, and/or with the aid of standardized diagnostic instruments. Autonomous individuals and their cognitive processes tend to be viewed, and specifically by CT, as separate from their interrelationships with other elements, such as time, context, social networks, or the therapist (Freeman & Garety, 2004).

It was only more recently that an attempt has been made "*to integrate CT with developmental theory, in particular Bowlby's cognitive-ethological model, which stresses the importance of early object relations in forming schemas that affect later interpersonal relationships*" (Ottens & Hanna, 1998, p.315). As formerly unpacked, the same occurred for the importance assigned to the therapeutic relationship by CT (Ottens & Hanna, 1998). Therefore, CT presently incorporates, into its framework, clients' relationships, as these happen happened in the past, outside the consultation room, and as these happen inside the consultation room. Yet, as

discussed, the meaning of relational is much broader for ETs, and whatever current focus on past and present relationships CT may now have is still peripheral to the theory.

In summary, CBTs tend to value objectivity, standards, norms, and evidence. On the other hand, ETs tend to value subjectivity, and situated relational experiences. As implicit to this discussion, tThis theoretical positioning bears great practical implications. For example, whereas CBTs seek to eliminate distress-inducing anxiety, or angst, ETS, such as logotherapy, may instead seek to sustain a certain level of distress-inducing anxiety, for it potentially prevents feelings of alienation and suicidal tendencies (Frankl, 1959, 2017). Integration-oriented clinicians may experience this clash, and feel insecure about which to value more, in specific circumstances and moments.

1.6.3 Meaning-making in ETs and CBTs

Despite the differences highlighted in the preceding section, both ETs and CBTs value the therapeutic benefits of what ETs would name meaning-making, and associate with the Husserlian "*arc of intentionality*" (Deurzen, 2014, p.54), and what CBTs would name deliberate and cognitive information processing (Beck, 1991; Beck & Beck, 2011; Ellis, 2005a; Moss, 1992; Prasko et al., 2012), or reasoning, for short. In both approaches, what is put at the centre of mental health, and deemed capable of distinguishing unhealthy from healthy experiences, for ETS, or processes, for CBTS, is the quality of this act. It is not whatever might have happened to the client in actuality. The event itself, or 'real' intentional object, is irrelevant.

Moreover, one of the qualities demonstrative of healthy reasoning processes, or meaning-making experiences, seems rather equivalent across approaches. This quality was named

"*cognitive flexibility*", as opposed to, for example, the adoption of "*absolute, rigid "truths*" by Beck (Beck, & Rector, 2000, p.292; p.297. For Ellis, "*the concern of the assessment is the broadness vs narrowness in perspective and rigidity vs. flexibility in belief style*" (Nielsen, Johnson, & Ellis, 2001, p.71), with health siding up with relativism, non-generalization, and flexibilitySome evidence to support this claim, as related the reduction of dichotomised views of the world (Paykel, 2007) and mental flexibility (Hayes et al., 2006), has been gathered.

Entering the work of more clearly existential thinkers, references to an equivalent quality are detected. For one, health rests closely on the ability to embrace "*multiple perspectives (…) into one's view*" for Deurzen (2012, p.234). For Frankl and Solomon (1992, p.602), reason and emotion alike must flexibly take into account the "*contingencies of the human condition and the circumstances of particular cultures and situations.*" Therefore, there is little on the side health that holds the character of universal truth. Thus, for some ETs and CBTs alike, healthy meaning-making must be adaptable and flexible, as opposed to rigid and immutable.
Yet, in defining meaning-making, "*standard CT (...) ascribes primacy to cognition*" (Ottens & Hanna, 1998, p.314). Said differently, CBT-as-CT views meaning-making as the fruit of intellect and reasoning. It also discriminates these cognitive acts, from emotional and behavioural acts, and utilizes e the criterion of rationality to distinguish between mental health and mental illness.

On the other hand, ETs stress the inter-relatedness of all things, inclusively of the nature of meaning making acts. Then, existentialist and REBT therapists could easily conceive of the emotion of sadness as a way of giving meaning to a moment of loss. As noted by the existentialist Solomon (1992, p.609), reason is often distinguished from emotions, as if "*emotion as such were devoid of reason, concepts, symbolization and argumentation,*

autonomy, will, effectiveness, insight, fairness, culture, and history". That is, from a more existentialist standpoint, the frontiers between Beck's cognition, and Beck's emotion are not so clear cut. For example, spiritual beliefs, including religious ones, are often deemed helpful during one's pursuit for meaning and authentic living under ETs (Deurzen, 2014). Yet, their rationality and logic is certainly questionable from CT's viewpoint.

Similarly, in being more outwardly influenced by ETs, to describe the tenets of REBT, Ellis (2005, p.205) remarked that "*human thing and emotion do not constitute two disparate or different processes but instead significantly overlap.*" Therefore, that for which meaning-making stands for in CBT-as-CT cannot be equated with what it stands for in ETs, or even CBTs-as-REBT.

1.6.4 Existential and Phenomenological Influences upon ETs, CT, and REBT

In preceding sections, it was noted that CT and REBT, as CBT sub-modalities, and every ET had been influenced, from the moment of their conception, by existentialist and phenomenological philosophies. The implication is that these psychotherapeutic modalities share some philosophical assumptions. An example is the aforementioned valuing of the act of meaning-making and cognitive flexibility (Edwards, 1990; Gebler & Maercker, 2014; Moss, 1992; Ottens & Hanna, 1998), present in CT, REBT, and ETs. Additional assumptions that have been said to reflect phenomenological assumptions within CT frameworks include the valuing of personal experiences and time (Moss, 1992). Therefore, it is not so much that CBTs and ETs were integrated with one another, in the sense of integration discussed at the beginning of this chapter. It is more that sub-modalities from these fields, knowingly or not, drank from the same existentialist and phenomenological pool of ideas, and saw their practices influenced

by existentialist and phenomenological arguments. In this section, some of these influences will be explored.

The common or, depending on the perspective, coincident tenets, across phenomenology, existentialism, and psychotherapeutic modalities, are most noticeable in Ellis' REBT (Ellis, 2005a; Ellis, 2005b; Ellis, 1980). As the author recognized, when the term CBT started to be used more loosely, which happened mostly during the 1990s, both REBT and ACT were included under the broad umbrella term CBT. Beforehand, the term tended to be used to refer to CT, and eventually CT and BT. Initially, Ellis fought hard against the identification of his psychotherapeutic modality with CT. In his opinion, CT and REBT had important distinctions in practice and in theory, as should be clearly differentiated from one another (Ellis, 2005a; Ellis, 2005b; Hyland & Boduszek, 2012; Weinrach, 1996). Namely, the integration of ETs on REBT was much more extensive than on CT, since the first wave of CBT, which occur, as noted, in the 50s and 60s.

More recently, Ellis further explained that third-wave modalities had embraced one or another of REBT's claims, which CT had neglected, and many of which were linked to the phenomenological-existentialist philosophies that he himself had embraced during the first wave (Ellis, 2005a; Ellis, 2005b; Hyland & Boduszek, 2012). Namely, REBT and many third-wave modalities accepted the complexity of the aetiology and treatment of mental disorders and suffering. These disciplines also embrace the therapeutic importance of mindfulness and acceptance, inclusively regarding Heidegger's flux of experience. Hence, REBT and third-wave modalities have been greatly influenced by philosophical claims.

On the other hand, Beck's cognition-based views, at the basis of CT, neglected these aspects. Specifically, as previously cited, Beck claimed that there were 'erroneous perceptions' that needed to be corrected (Beck, 1991). This particular assumption is problematic in many different ways. First, for Beck, as formerly discussed, perceptions amount to thoughts like NATs. This does not correspond to the psychophysical definition of perception. In the long tradition laid down by the well-known Gustav Fechner (Lappin, Norman, & Phillips, 2011), and current neuropsychology studies of perception (Diamond, & Arabzadeh, 2013) alike, perceptions are about responding to, and/or representing sensorial information received from their internal milieu, for the case of proprioception, and received from the environment, for the most commonly discussed senses, like vision and hearing. Perceptions are definitely not reasoning, reflection, analysis, or information processing.

As acknowledged by Diamond, and Arabzadeh (2013, p.29), it is not because "*understanding how organisms know what is "'out there'' in the world has long been a challenge,*" that the equation should be simplified to become a 'thought', as CT does. For Fetchner and neuropsychologists alike, what is represented in the brain, if represented at all, emerges from the interaction between the perceiving person and the environment. It is not circumscribed to the brain, or created by the person in isolation, cut off from the environment.

Hence, the first issue with Beck's claim is the use of the term perception. The second issue is his presumption that there were perceptions/thoughts that were 'irrational', 'incorrect', wrong, or faulty. Put simply, "*CT treats clients' assumptions as in need of correction rather than careful examination"* (Ottens & Hanna, 1998, p.313). Moreover, NATs were simultaneous a symptom of mental disorders, the cause of the disorder, and the disorder itself. For example, the thought 'I am a failure' is wrong, irrational, a symptom (of depression, for example), the

disorder (an unhealthy thought), and the cause of the disorder, that needs to be treated and replaced by more logical thoughts (such as a thought like 'I sometimes am a failure'). As previously remarked, this is sort of a distortion of the way medical disciplines define aetiology, or cause, and symptoms. In medical disciplines, the cause of a disorder and its symptoms are not one and the same. For example, infections cause fever. Fever is the symptom. The disease is the infection.

Unlike wise, existentialist therapists, if congruent with their ET framework, would never classify perceptions or thoughts as 'wrong', would not seek to replace or correct these thoughts, would not equate mental health with rationality, and would not claim that a thought was the cause or symptom of a client's problems. Instead, they are to embrace the complexity of everything (human nature, suffering or 'pathologies', aetiologies, treatments….), and would rather explore the thought, integrating it in overall functioning, and promote clients' adaptiveness to personal and external circumstances whenever possible (Ottens & Hanna, 1998). As explained by Ellis (2005a, p.156), "*Beck emphasizes empirical formulations and information processing in CT, while I strongly emphasize profound and fundamental philosophical change—which includes a philosophy of feeling and of behaving functionally"*.

At face value, replacing a thought, as aimed by CT, and fostering new philosophies of life, as aimed by REBT, may seem rather the similar goals. However, Ellis' 'new philosophy' (Ellis, 2005a; Ellis, 1980; Dryden & Neenan, 1999; Joseph, 2012; Rosner, 2011) is necessarily complex (vs. rational), comprehensive (vs. isolated easily in its singleness, as the aforementioned NAT), reactive to stimuli and surrounding circumstances (vs. mostly cut off from their environment), and integrative (vs. selective about what must or not be discarded, inclusively irrational thoughts).

Thus, REBT is best regarded as a CBT modality but one which integrates, theoretically and practically, a vast set of phenomenological assumptions in its theoretical and practical core. For instance, at the level of practice, CT (and BT) follows a very active-directive treatment protocol. It starts by diagnosing, then treating what was diagnosed via a set of greatly standardized steps, and then finally evaluating outcomes. Finally, in CT, there is, as discussed, a clear identification of rationality-with logic, and of irrationality with illogical. The aim of therapy is to increase rational processes and minimise irrational ones. CT desires a rational world, easy to predict and program.

On the other hand, Ellis (2005a, p.155) uses the term rational in the sense of adaptive, reasonable, or sensible. It is not used in the sense of logic ad rational, as Beck does. For Ellis, it is even the case that "*people are often irrational and unsane—including therapists.*" This lack of reason was only deserving of more considerate psychotherapeutic attention when having destructive and maladaptive functions at biological, psychological, or social levels. Even in this case, therapists were not to simply replace it, as under CT.

Moreover, flexibility, understood a collaboration with clients that is incompatible with structured and fixed processes and outcomes, such as diagnoses and treatment protocols, is key for REBT and ET (Dryden, 2009). Very much in line with Heidegger's flux of experiencing, it is even argued that diagnoses should not be formulated. Instead, permanent change should be expected. REBT therapists must be willing to adapt permanently to the clients' preferences. If the client is not willing to go through an intervention, or rejects a therapeutic decision, then their volition ought to be respected. Clients and therapists are expected to '*work together to co-direct their sessions'* (Ellis, 1985, p. 251).

REBT's preference for flexible approaches does not mean that REBT rejects every form of structure or protocol. Instead, just like CT, the therapeutic process sometimes involves explicit structures and an "*active-directive*" (Ellis, 2005a, p.155) approach. For example, REBT therapists are recommended to teach clients how to use the REBT model at the start of therapy, and to follow three treatment stages: examine the disturbance; review the dissatisfaction; and move on to development (Joseph & Chapman, 2013). For some authors, this means that REBT is 'trans-diagnostic' (Edwards, 1990; Rosner, 2011).

Reinforcing the observation that REBT was originally greatly influenced by ETs, Ellis often discussed how to incorporate 'more' phenomenological tenets into his approach, not how to incorporate ETs and CBTs. As Ellis explained:

> Existential therapists […] can show their clients the possibilities of making choices and changes, but unless they actively encourage them to keep working at changing, many clients […] will only sporadically do so. REBT realistically merges existential therapy with active-directive teaching and mentoring (Ellis, 1985, p. 252).

Then, REBT is viewed as an integrative discipline, integrating ETs and CBTs, by its very own main founder. It incorporates flexibility and structure, by offering consistent exploration, introspective dialogue, and exercises focused on training the conscious mind to understand the power of the individual. For the author, this strategy forces clients towards freedom of thought and action.

For Hyland and Boduszek (2012), CT and REBT could be incorporated if the goal of therapy became to simultaneously identify individual NATs or whole schemas, such as it happens under CT, and support clients' discovery of alternate ways of living, feeling, and behaving (vs. eradicating errors) in response to events, as it happens for REBT. The authors further proposed that a different, 'exploratory', non-directive and pre-set form of identifying and modifying one's being-in-the-world was beneficial. This attitude, deemed as lacking in more active-directive approaches to therapy, resembles phenomenological methods, as these have been portrayed here. In essence, this means that the authors believed that CT and REBT could be integrated, and see their philosophical tenets expanded.

In summary, ETs, CT and REBT value meaning-making. Yet, CT is keen on cognitive flexibility exclusively, on structured processes, and on instigating rational and logical thought information processing in clients. On the other hand, REBT frames its practice within existentialist and phenomenological assumptions more outwardly, and knowingly. Flexibility, as collaboration with clients in a manner sensitive to Heidegger's flux of experiencing, incompatible with structured processes and outcomes, is instigated. Moreover, adaptation, to the environment and one's characteristics, is seen as healthier than logical reason. Nevertheless, it seems theoretically possible to incorporate REBT with CT, by broadening its scope and understanding of mental health by incorporating more existentialist attributes into these CBT modalities.

1.6.5 Third-Wave Modalities and Existentialism

Third-wave modalities have often been recognized to incorporate phenomenological tenets (Ellis, 2005a; Gebler & Maercker, 2014; Prasko et al., 2012). For instance, mindfulness

techniques are increasingly common in therapy, principally in third-wave modalities like ACT, MBCT, and other integrative programs (Fegg et al., 2013; Hayes, 2004; Teasdale, 1999; Teasdale et al., 2001). These revolve around enhancing moment-to-moment self-awareness. Practically, and conceptually, this emphasis partially coincides with the phenomenological method, as applied to the study of the lived experience, relating clearly to an experiential dimension (Claessens, 2009), albeit, again, possibly lacking in Husserlian's systematicity.

Mindfulness techniques can also be regarded as originating from, and common in, Eastern spiritual contexts. Those arguing in favour of the use of mindfulness also often argue in favour of incorporating spiritual topics within therapy (Brown, Ryan, Loverich, Biegel, & West, 2011; Greeson, 2009; Fegg et al., 2013). These techniques are said to bring into therapy a much-needed focus on the acceptance and exploration of clients' conscious and present emotions and thinking, rather than working on, and often getting stuck on, unravelling the matters of the unconscious and automatic thoughts.

Third-wave modalities' goals are more similar to those of ETs than to those of CTs. For Gebler and Maercker (2014), the similarities between ACT and existentialist are even "*obvious*" (Gebler & Maercker, 2014, p.158). It is a "*psychological flexibility model*" that can "*lead to the generation of innovative experiential, relationship-based, and intensive treatment methods*" (McCracken & Morley, 2014, p.221).

In sum, some third-wave modalities, such as those revised here, are argued to have attempted to integrate more phenomenological practices and beliefs into their approach to mental health than CT, and even REBT.

1.6.6 Empirical Studies about the Integration of ETs and CBTs

As explored in the preceding section, whomever is pursuing the integration of ETs and CBTs should acknowledge that both ETs, and CBTs, and in particular REBT, have been influenced by phenomenological and existentialist tenets from the very beginning. For this reason, it seems fairer to argue that one is pursuing a more extensive integration of philosophical assumptions in CBTs, or in ETs, than to claim that is pursuing, and much less as never before, the integration of ETs and CBTs. Yet, for simplicity, the topic will be referred to here as a case of the integration of ETs and CBTs.

One of the arguments used to justify these integration attempts, although often merely implicitly, falls along the lines of the 'additive integration hypothesis', discussed at the beginning of this chapter. Several authors proposed that the integration of ETs and CBTs might bolster the strengths of both therapy types and mitigate their weaknesses (Ameli, 2016; Ameli, & Dattilio, 2013; Binnie, 2010; Cohen, Mannarino, & Staron, 2006; Edwards, 1990; Ghaemi, 2001; Gebler & Maercker, 2014; Norcross, 1987; Ottens, & Hannah, 1998; Prasko, Gambral, Kamarodova & Jelenova, 2012b; Sørensen, 2015).

Many authors explored this hypothesis theoretically, by identifying the compatibility, complementarities and differences between ETs and CBTs – eventually all while recognising the phenomenological influences behind CT, and, to a greater extent, REBT and third-wave modalities like ACT and MBCT (Ameli, 2016; Ameli & Dattilio, 2013; Edwards, 1990; Ottens, & Hanna, 1998; Prasko et al., 2012). A non-systematic attempt at this theoretical exploration was made in preceding sections, when discussing the different stances of CBTs and ETs regarding subjectivity, objectivity, meaning-making, and the therapeutic process.

As in this chapter, Ottens and Hanna (1998) also debated the compatibilities and incompatibilities of CBTs and ETs at length. They offered some theoretical ideas about how CBT therapists' range of tools could be extended, by incorporating existentialist ideas about the value and character of the following aspects: therapeutic relationship; interpersonal and environmental factors; sociotropy and autonomy; and meaning-making.

Ameli and colleagues (Ameli, 2016; Ameli & Dattilio, 2013) did a similarly extensive review but covered both theoretical and technical aspects, rather than theory alone, as Ottens and Hanna (1998). They posited that logotherapy and CT shared many technical aspects, including their use of "*a process of 'guided discovery' without the therapist imposing his/her personal concepts of reason or meaning*" (Ameli, 2016, p.213), valuing the therapeutic alliance, valuing empirical studies and being solution-focused. For Ameli, then, CBT already valued the therapeutic relationship and clients' autonomy, and did not impose meanings upon clients' thoughts. This opinion clashes slightly with what has been claimed in preceding sections, and Ottens and Hanna's (1998) discussion. It is however possible that she was bearing REBT in mind when discussing CBT, for REBT indeed shows these traits, as previously discussed, as REBT is sometimes equated with CBT, even if only more recently with Ellis' acquiescence.

Despite these disagreements, nothing in the literature is suggestive that CBTs and ETs cannot be integrated or are incompatible in irrevocable ways. Without necessarily proving this presumption of compatibility right, a couple of new modalities, explicitly seeking to integrate (more) ETs into CBTs at a theoretical level, have been developed (Armstrong, 2016; Hutchinson, & Chapman, 2005). There are also a couple of intervention programs integrating these modalities at the level of standardized practices, conducive of empirical efficacy testing (Fegg et al., 2013; Gagnon et al., 2015; Gebler & Maercker, 2014). These programs did not

identify the type of integration there embraced, but apparently utilised some sort of 'technical eclecticism' and assimilative integration strategies. Their aim was to check the efficacy of approaches which complemented CBT by filling in its gaps (that is, criticism regarding lacking elements) through the incorporation of tools or approaches associated with ETs.

Overall, these integrative efforts have recommended the integration, into CBTs practices, of a set of ETs-based tools, These apparently beneficial tools are: spiritual meaning-making discussions (Ameli, 2016; Ameli & Dattilio, 2013; Armstrong, 2016; Fegg et al., 2013; Gagnon et al., 2015; Gebler, & Maercker, 2014; Hickes, & Mirea, 2012; Hutchinson & Chapman, 2005; Ottens & Hannah, 1998; Prasko et al., 2012), often as specifically derived from Frankl's logotherapy (Ameli, 2016; Ameli & Dattilio, 2013; Armstrong, 2016; Gagnon et al., 2015; Gebler, Hutchinson, & Chapman, 2005); the utilisation of 'exploratory', non-directive, 'empathic', fluid therapeutic attitudes aimed at the identification and/or modification of clients' being-in-the-world (Edwards, 1990; Gebler & Maercker, 2014; Hickes & Mirea, 2012; Ottens & Hannah, 1998); the particular character of an existentialism-based therapeutic relationship (Edwards, 1990; Gebler, & Maercker, 2014; Ottens, & Hannah, 1998); a focus on positive emotionality and clients' strengths, either as a technique or sought outcome (Ameli, 2016; Armstrong, 2016; Hutchinson & Chapman, 2005); the consideration of clients' interpersonal relationships, as sustained outside the consultation room (Armstrong, 2016; Ottens & Hannah, 1998; Prasko et al., 2012); the fostering of clients autonomy, freedom of choice and responsibility (Ameli, 2016; Armstrong, 2016; Gagnon et al, 2015; Hickes & Mirea, 2012; Hutchinson & Chapman, 2005; Ottens & Hannah, 1998; Prasko et al., 2012); and acceptance of life circumstances (Gagnon et al., 2015; Gebler & Maercker, 2014; Prasko et al. 2012) – a concept which became less clearly grounded on ETs when third-wave modalities started

employing Buddhist mindfulness methods and describe these as the ability to accept, this once inner, vs. external present events (e.g., Fegg et al., 2013).

Note that the quality of the therapeutic relationship has been greatly explored by several modalities which are not necessarily and consistently classified as existentialist. Rogers' client-centred approach is an example. Similarly, in regards to the inclusion of discussions of spiritual matters, not everyone who seeks to incorporate these aspects into CBTs is formally and explicitly influenced by existentialist thought. For instance, Balboni et al. (2010) and Zoellner and Maercker (2006) developed or tested an intervention program focused on addressing spiritual (relationship to and experience of the transcendent) and religious (religious practices shared by communities) issues without linking their program to ETs explicitly. That is, discussions regarding spirituality or more flexible forms of relating to clients are not exclusively or explicitly driven from researchers' intent to integrate ETs into another modality.

At a practical level, of the reviewed integrative intervention programs, some were designed to address a specific target population, such as cancer patients (Gagnon et al., 2015), informal caregivers of palliative patients (Fegg et al., 2013), those suffering from post-traumatic stress disorders (Zoellner & Maercker, 2006), and those experiencing chronic pain (Gebler & Maercker, 2014). Additionally, some were crafted to address or enhance a specific outcome measure, such as spiritual meaning-making (Gebler & Maercker, 2014), pain measurement (Gebler, & Maercker, 2014), life satisfaction, quality of life and/or wellbeing (Fegg et al., 2013), and psychological distress (Fegg et al., 2013). Some of these objectives, more than others, do not correspond to symptoms of the populations disorders. This is consistent with existentialist perspectives.

Although it is untrustworthy to establish any concurrent validity notions, some of these integrative attempts will be described in more detail for illustrative purposes. For instance, Gagnon et al. (2015) tested their integrative and manualised 12 week-long intervention program empirically. It included CBT's behavioural tools (e.g. relaxation and cognitive restructuring), tools from an approach which utilises spirituality and meditation for dealing with the emotional distress of life-threatening diseases, and existential tools modified from logotherapy. This program was offered under group and individual settings and compared to 'usual care' interventions. Unfortunately, little was offered to describe what happened to those under the usual care condition, leaving little margin to understand the program comparatively.

Despite this, their RCT can illuminate the efficacy of their program on non-clinically depressed cancer patients' existential well-being and general quality of life at post-intervention and three months follow up. They found medium to large effect sizes on both measures, which, at post-treatment and three months post-intervention, were higher than those obtained in the usual care group. They concluded that their intervention was feasible and efficacious, at least in the short-term. However, they did not report the six-month and one-year follow-up assessments which had been planned at the beginning of the project.

In addition, Gebler and Maercker (2014) conducted a pseudo-experimental clinical investigation of the effects of CBT, as compared to a program integrating CBT and ET, for the ten-week long treatment of chronic pain. CBT groups were delivered 'standard' CBT chronic pain treatment, consisting of cognitive and behavioural techniques. The groups differed only in that the integrated version of the program replaced two standard-CBT pain management sessions, about 'attention, distraction and enjoyment' and 'operant factors of chronic pain',

with two ET-inspired sessions about 'acceptance of loss and suffering' and 'values and meaning'.

During the integrated version of the intervention, therapists attempted to adopt "*an overall existential attitude*" (Gebler & Maercker, 2014, p.162), and one which likely was less "*directive and focused on the active therapeutic pursuit of change"* (Gebler & Maercker, 2014, p.1), which is how the authors described the attitude of CBT therapists. They found that the integrated version of CBT was superior in efficacy for reducing pain severity ratings at post-treatment. Moreover, whereas standard CBT did not show any significant effects at any follow-up moment, the integrated version showed a moderate effect size across assessment moments, except at six-month follow-up, for which moment effect sizes were small. Interestingly, these effects were greater for spiritually-inclined people. Finally, pain-related disability showed no variation per group, but was significantly lower at post-treatment and thereafter.

In sum, authors have offered different solutions and answers to the value and praxis of integrating ETs and CBTs. These programs included one or another of the formerly identified attributes that characterise ETs, and always offered their integration with CBT as beneficial. Some research has provided empirical evidence in support of the benefits of this integration (Fegg et al., 2013; Gagnon et al., 2015, Gebler & Maercker, 2014). In addition, efficacy studies comparing ETs and/or CBTs to control groups point towards the individual value of these approaches. Thus, the idea that the integration of ETS and CBTs is beneficial remains to be fully empirically demonstrated.

1.7 Concluding Remarks

Overall, the literature review process described in the present chapter was mostly narrative and non-systematic, and therefore can result in selective bias. However, this was, after all, an author piece. The intention was to share the author's viewpoint and reasoning, all while leaving on the table the complexity of the topic under study. There never was an intention to be comprehensive and exhaustive. Then, it is possible some studies were overlooked, or overvalued, but that hopefully the struggles afflicting those integrating, or wishing to integrate CBTs and ETs, were fairly represented.

The chapter started by describing the main motivations behind the present investigation. It continued by identifying some of the presumptions behind the recommendations of NHS, and of integrative efforts. Namely, it described how both these approaches to the treatment of mental health embraced, even if unknowingly, the herein coined 'granularity' assumption. It posits that modalities have differential value. As discussed in the first section, this assumption is defied by the so-called 'equivalence paradox', which illustrates how modalities have equivalent efficacy in meta-analytical studies. Yet, this assumption has a long history in the field of clinical psychology and psychiatry, and is at the core of every integrative modality. One must first accept that the type of modality matters, to thereafter seek to pursue their integration. The second assumption required for embracing the effort of integrating modalities is that the advantages of each modality can be combined, in an additive manner, to increase their efficacy, or scope.

The fourth and fifth sections reviewed historically, as critically and systematically as possible, literature concerned with the state of the art of CBTs and ETs, respectively. It showed how both modalities, though principally CBT, are labels used to refer to rather heterogeneous

modalities, with very distinctive beliefs and practices. In also discussed how CBT appears to be the non-pharmacological treatment of choice within the NHS for most psychiatric disorders (Paley et al., 2008; Parker et al., 2003), and despite there being meta-analytical studies defying the superiorly of CBT.

The sixth section explored how these modalities have been, and can be more extensively integrated in the future. Integration-wise, the label CBT seems to refer to a technical eclectic practice (which is not necessarily the best integration strategy), that offers (controversially) tools crafted within the most diverse theoretical tenets. Its application is structured by objective protocols, short-term, evidence-based, assessment-guided, diagnostic-oriented, and condition-specific methods. ETs, in their pursuit of subjectivity, tend to offer resistance to measurements and standardization, and thereby to remain absent of therapeutic practices of health institutions. Finally, there are CBT modalities, such as REBT and third-wave modalities, which already integrate at their core some of the philosophical assumptions and practices embraced by ETs. These can be argued to consist of integrated modalities, most of which resolving in their own manner the tension between the objectivity and subjectivity that so markedly divides these approaches. Finally, empirical studies concerned with modalities which sought to incorporate CBTs and ETs more extensively, or in ways not well accounted for as REBT or third-wave modalities, were reviewed. These showed there may be an advantage in their integration, such as for exploring spiritual and religious issues with clients

The remainder of this study will attempt to build upon these achievements and provide a more thorough understanding of the potential and practicalities of developing of integrating, into a CBT intervention, existential dimension. Research questions will first focus on the extent to which therapists are content with CBT and their willingness to integrate existential ideas for

the benefit of clients, and of their own therapeutic success. Thereafter, practitioners will be questioned about their professional and personal beliefs and experiences concerning the merits and struggles of embracing an integrative approach, at philosophical and practical levels. These studies had, for the greater part, descriptive intents. Quantitative and qualitative methods were used to describe clinicians' experiences and opinions. The only quantitative hypothesis tested was about whether dissatisfaction with CBT was correlated with heightened existential thinking.

Chapter 2 – Description and aims of the study

Mixed Methods Research
Part 1: CBT satisfaction and existential thinking online survey - SPSS Analysis of Scales and content / thematic analysis of open-ended questions *('mixed strand')*
Part 2: An Interpretative phenomenological analysis (IPA) of existential attitude in cognitive therapists *('qualitative strand')*

2.1 Introduction

This research study investigates the self-reported opinions and experiences of CBT therapists regarding the possibility of implementing an additional existential component to CBT.

This research will consider two related research questions:

1. *Why might cognitive behavioural therapists consider existential ideas in their work? This explores therapists' satisfaction with using CBT alone in therapeutic practice.*
2. *When therapists do try to combine CBT with existential ideas, how do they do so and what is their experience of this?*

Cognitive behavioural therapists in the present study include the following professionals: CBT therapists, clinical/ counselling psychologists, counsellors, experienced graduate mental health workers, and psychotherapists. These professionals are accredited or are eligible for accreditation by the British Association of Behavioural and Cognitive Psychotherapies (BABCP).

This research aims to elucidate the benefits of a clearer understanding of more effective CBT practice by therapists. In order to answer the two aforementioned research questions, this research comprises two studies:

Part 1 – An online survey to explore satisfaction with CBT and incorporating an existential component.

Part 2 - Interviews to explore therapists' experiences of using an existential component of therapy in combination with CBT.

2.2 Part 1: Online study- CBT satisfaction and existential thinking survey

Part 1 reports on an online survey designed to explore psychologist practitioners' and trained CBT therapists' satisfaction with CBT, their opinions about possible links with existential thinking, and their views about adding an existential component to CBT. The online survey was designed in accordance with the British Psychological Society's (2013) guidelines on conducting research via the internet, and the data was analysed using both quantitative and qualitative methods.

The survey had three objectives:

1. To test the hypothesis: *As 'existential thinking' increases, satisfaction with CBT decreases.*
2. To determine CBT therapists' satisfaction with CBT.
3. To better understand CBT therapists' perspectives on incorporating an existential component within CBT practice.

The online survey comprises three scales and four optional response questions, which are as follows:

1. **CBT Satisfaction scale (CBT-S)** to investigate satisfaction with CBT in practise (8 items).
2. **Scale of existential thinking (SET)** intended to assess the form and degree of existential thinking (11 items).
3. **CBT with an Existential component scale (CBT-E)** to investigate the possibility of integrating CBT with existential themes (4 items).
4. **Optional free response questions** to allow further details or further comments on the issues raised by the survey (4 items).

2.3 Part 2- IPA study: Interview to explore the experiences of using existential components with CBT

The second research study used interviews to explore the experiences of practitioner psychologists and trained cognitive therapists in using existential components within their CBT practice working with clients. Eight BABCP accredited CBT therapists were selected and the interviews were analysed using Interpretative Phenomenological Analysis (IPA).

The IPA had two objectives:

1. To explore the experience of accredited CBT therapists in the use or attempted use of existential components in their practise of CBT.
2. To understand how these existential components were incorporated within CBT.

Chapter 3 – Mixed methods research methodology - CBT Satisfaction and Existential Thinking Survey, and Interpretative Phenomenological Analysis

3.1 Introduction

The preceding chapters provide an in-depth discussion concerning the efficacy or lack thereof of different therapeutic approaches, specifically those primarily rooted in cognitive therapy traditions. Through this discussion, a strong case was presented for the argument that a hybrid approach, one that combines CBT and existentialism, can help clients to deeply understand and manage a wide array of issues and interpersonal struggles effectively. Such a hybrid approach also allows for a collaboration of reason, emotion, and questioning of life in a manner that is atypical in other approaches. The overarching objective of this research endeavour was to investigate the extent to which therapists gravitate towards, or are repelled by, CBT in its current form; whether and how they would integrate existential ideas in their CBT practise; and what the experience would be for them if they tried to do so.

This chapter details the methodology used in this mixed methods project. It firstly describes the research design adopted for part 1 of the study, the CBT Satisfaction and Existential Thinking Survey; explaining how the survey participants were accessed, how the questionnaire was designed, how data was collected, and the statistical procedures used for data analysis. There is also a discussion about the methodology used for the analysis of the open-ended questions in the survey. For simplification sake, this part is referred to as the 'Online Survey'.

The chapter then describes part 2 of this study, the Phenomenological Analysis of Existential Attitudes among Cognitive Therapists, which will be critically examined and justified. The Interpretative Phenomenological Analysis (IPA) study serves to explore and highlight the

various beliefs and experiences of participants regarding the usefulness, or lack thereof, of ET approaches; a departure from the more restrictive survey approach employed in part 1. It also allowed participants to more freely share their thoughts as well as expertise.

3.2 Part 1: Online survey ('mixed strand')

Part 1 of this project assessed the attitudes and beliefs of practitioner psychologists and trained cognitive therapists regarding practice-related linkages between CBT principles and existential thinking practice. To examine these issues, an online survey, consisting of mixed closed-question, scaled responses, and open-answer questions, was developed with four sections identified in section 3.2.4.

3.2.1 Participants and Sampling Procedures

A total of 243 participants volunteered to participate in the study. They were recruited via an advert in the British Association of Behavioural and Cognitive Psychotherapies (BABCP) member magazine, CBT Today (Appendix 2). The advert directed participants to a research portal website (Appendix 3), which was linked to the Psychdata hosted online survey (Appendix 4). This hosting site offers a reputable service for the social science community, has over ten years of experience in conducting internet-based research, and includes secure data storage, enabled with password access. All participants completed all aspects of the study; thus the research conforms to an independent groups design.

Eligibility requirements for participation in the online survey were twofold: 1) participants needed to attest that they were a Psychologist or Therapist trained in and currently delivering

CBT; and 2) they needed to be accredited members of the BABCP or another Cognitive Therapy accreditation organisation.

3.2.2 Stimulus and Materials

Each section of the survey was designed to elicit information to measure various dimensions of the research questions. Two of the research scales (CBT-S and CBT-E) and the optional free-response questions were designed by the lead researcher, after confirming the absence of suitable available tools amidst the reviewed literature. The third scale, Scale of Existential Thinking (SET), is a published scale and was selected following a literature review of potentially suitable scales (Allan & Shearer, 2012). SET was selected because it was deemed to be the most appropriate established scale for this research project. It isolates attitudes on existential thinking, especially in a manner that addresses spirituality. Issues of existence and spirituality are not common themes within CBT communities of practice.

3.2.2.1 The CBT Satisfaction Scale (CBT-S)

The CBT-S consisted of an eight-item set of original questions designed by the researcher to help ascertain the general degree of knowledge, comfort, and usefulness the respondents felt regarding CBT. It probed respondents' beliefs about their use of CBT to address a wide range of topics, including existential issues. The respondents rated how much they agree with the statements on a 5-point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree. Items included 'I find CBT techniques provide me with all the tools I need in my therapeutic work' and 'Overall I am satisfied with the use of CBT with my clients' (Table 1).

3.2.2.2 The Scale of Existential Thinking (SET)

The SET is an 11-item scale developed by Allan and Shearer (2012) to measure the extent to which respondents engaged in “existential thinking”. This was defined by Allen and Shearer as reflective thought about the core issues of human existence, and one’s ability to find eaning and one’s place in respect to ultimate concerns about life now and in the future. Respondents rated how often they think about existential concepts on a 5-point Likert scale ranging from 0 = I don’t know to 5 = all the time. Items included ‘Do you ever reflect on your purpose in life?’ and ‘Do you ever think about life's "big questions"?’

The SET has demonstrated strong test-retest reliability (r = .91) and internal consistencies ranging from α = 0.88 to α = 0.94 (Allan & Shearer, 2012). Convergent validity of the scale was shown through significant correlations between the scales of theoretically related constructs, including the Spiritual Intelligence Self-Report Inventory (r = 0.67) and the existential subscale of the McGill Quality of Life Questionnaire (0.67; Allan & Shearer, 2012). The correlations were not high enough to make the SET redundant which provides evidence for the scale’s divergent validity as spiritual intelligence and existential thinking are separate yet highly related constructs (Nobandegani et al., 2015).

3.2.2.3 CBT with an Existential Dimension Scale (CBT-E)

The CBT-E consisted of a four-item set of original questions designed by the researcher. The subscale asked respondents about the applicability of existential concepts to their practice, whether or not they have already applied them, and/or if they have plans to do so in the future, even if this required additional training. The participants rated how much each statement applied to them on a 5-point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree. As shown in Table 1, items included ‘I believe existential themes are a vital component

of any therapeutic approach' and 'I would consider using a meaning-based approach such as existential therapy with my clients.'

3.2.2.4 Optional Section (OS)

The optional open-ended section requested respondents' additional, unstructured, and voluntary input with regard to their knowledge, experience, and training in existential thinking or meaning-based therapies. The section compromised of four questions which included 'Outline your current awareness of meaning based approaches/existential themes, including any training you have received or personal research you have undertaken.' This section aimed to gain a rich and in-depth insight into the thoughts behind existentialism within the CBT arena. Collectively, the four subscales measured practitioners' satisfaction with CBT techniques, the extent to which they had been trained in, were knowledgeable of, and/or employed existential thinking in their practices, and how, if at all, they integrated the two concepts in their work. The open-ended section was intended to invite comments that would help explain the theoretical underpinnings of the practices employed by the respondents, as well as their thoughts on the study itself. In sum, the survey was used to test the hypothesis that as existential thinking increases, satisfaction with CBT decreases.

Table 1. CBT Satisfaction, Existential Thinking, CBT with Existential and Free response Survey Items.

	Scale 1 - CBT satisfaction (CBT – S)
1	I find CBT techniques provide me with all the tools I need in my therapeutic work
2	I would be comfortable using CBT techniques with my client regardless of the issues they present
3	My training in CBT techniques covered a comprehensive base of potential client issues
4	I have found CBT to be effective in situations involving the discussing of 'big issues', e.g. the purpose of life, the existence of God, anxiety or identity
5	I have in the past guided therapy sessions away from 'big issues' because I was unsure of how to use CBT to deal with them
6	I feel comfortable in freely adapting the CBT techniques learned during training
7	Overall I am satisfied with the use of CBT with my clients
8	I integrate other approaches (e.g. psychoanalytic, existential, systemic etc.) with CBT methods in my practice
	Scale 2 - Scale of existential thinking (SET)
9	Do you ever reflect on your purpose in life?
10	Do you ever think about the human spirit or what happens to life after death?
11	Have you ever spent time reading, thinking about or discussing philosophy or your beliefs?
12	Do you have a philosophy of life that helps you manage stress and crises or make decisions?
13	Do you think about ideas such as eternity, truth, justice and goodness?
14	Do you spend time in prayer, meditation or reflecting on the mysteries of life?
15	Do you discuss or ask questions to probe deeply into the meaning of life?
16	Do you ever think about a "grand plan" or process that human beings are a part of?

17	Have you ever thought about what is beyond the "here and now" of your daily life?
18	Do you ever think about life's "big questions"?
19	Have you ever reflected on the nature of reality in the universe?
	Scale 3 - CBT with an existential dimension (CBT-E)
20	I believe existential themes are a vital component of any therapeutic approach
21	I would consider using a meaning-based approach such as existential therapy with my clients
22	I have actively sought to improve my knowledge and/or ability with meaning-based approaches, such as the inclusion of existential themes
23	I intend to pursue the further integration of CBT techniques with existential themes in my own practice
	Optional free response questions
24	Outline your current awareness of meaning-based approaches/existential themes, including any training you have received or personal research you have undertaken.
25	If you have integrated existential themes into your CBT session in the past, outline your motives for doing so. If you have not, please outline your reasons for not doing so.
26	If you would consider integrating existential themes into your CBT sessions in the future, what would you hope to achieve by doing so?
27	If you have any other comments, please provide below.

3.2.3 Data Collection Procedures

Survey responses were recorded online and entered into the database upon completion. The online questionnaire was designed so that every question had to be answered before moving along the survey. A total of 16 (6%) surveys were excluded from the analysis due to participants

ending the survey before all questions had been answered or participants failing to press the final 'submit' button. This action was intended to act as a signifier that the respondent was happy with their responses and was making them available for use in the survey data.

3.2.4 Ethical Procedures

The ethical considerations are important for the research study to ensure that the data collected, used and interpreted is valid, reliable and holds academic significance. The proposal of this current research was reviewed and approved by the ethics committee of the New School of Psychotherapy and Counselling and Middlesex University.

To ensure strict abidance of ethical guidelines, prior to data collection, participants were provided with an information sheet and consent form which explained the study, what would be involved by taking part and covered ethical requirements such as confidentiality and the right to withdraw (Appendix 4). The participants digitally provided their consent and confirmed that they acknowledged that all data provided will be protected by clicking the 'accept' button. They were instructed to exit the page and not participate in the research if they did not agree to participate. The online survey was in accordance with the British Psychological Society 2013 ethical guidelines on conducting research via the internet.

In addition, all information collected during the course of the research was kept safely and strictly confidential. Data was anonymised through the removal of identifying information and the utilisation of pseudonyms and the anonymization of accounts.

3.2.5 Data Analysis

3.2.5.1 Quantitative Analysis

Statistical analysis was performed using the Statistical Package for the Social Sciences (SPSS) version 21 for Windows. The online questionnaire consisted of three scales, adding up to a total of 23 items. These scales are as follows: Scale of CBT Satisfaction (CBT-S) (8 items), Scale of Existential Thinking (SET) (11 items), and Scale of CBT with an Existential Dimension (CBT-E) (4 items). There further were three demographic questions (age, gender, and years of experience), a close-ended question inquiring whether there was an interest in being interviewed in the future.

Answers to scales were to be given via Likert-like scales of different ranges, and were descriptively statistically described thought the use of means and standard-deviations. For each question, parametric assumptions were examined, by running a Shapiro-Wilk test of normality. None of the variables was found to be normally distributed. Thus, the non-parametric Spearman's rho test was used for inspecting correlations. This statistical test proposes, as a null hypothesis, there is no relationship between two variables. The alternative hypothesis allows the conclusion that there is a significant relationship between the variables, at an established statistical significance level. Correlations were studied for overall scores, and item-by-item.

3.2.5.2 Qualitative Analysis

The free text responses were analysed using NVivo 10. The category formation process resembled thematic analysis (Guest, MacQueen, & Namey 2012) but frequencies of themes

and categories were also examined and reported as outputs, as with content analysis (Neuendorf, 2017). The overall process drew upon both these qualitative analysis methods.

In contrast to content analysis, thematic analysis allows for the assessment of concepts from a broader level and then narrowed in a manner that is less reductionist and bias-laden (Vaismoradi, Turunen, & Bondas, 2013). The use of thematic analysis involved interpreting patterns of meaning (or "themes") of the open responses by thoroughly reviewing the data and adapting and revising the resulting coding frame as the analysis progressed; In other words, the identification of themes was "*data-driven*" (Braun & Clarke, 2006, p.96) and inductive. The prevalence of particular themes was thereafter established by first producing the frequencies of each theme in a mode echoing content analysis, in terms of the number of different respondents mentioning each topic in their comments. Frequency tables were then produced, accompanied by a narrative from the comments aiming to provide more descriptive context to the findings.

Specifically, the analysis process involved reading through all comments, then setting up a coding frame in NVivo which included a list of the main topics across all comments. Following this, the comments were imported into NVivo as a source document and each comment re-read and allocated to one or more of the themes (known as 'nodes' in NVivo). This constructed part of the coding frame. The development of the coding frame was reflexive and ongoing throughout the analysis process, with new nodes being added and existing nodes amended as the process developed in order to ensure the best possible fit with the data. Frequencies of categories were then studied and reported upon.

While this approach to analysing data was essentially a 'thematic analysis', as set out by Braun and Clarke (2006), it also carried certain aspects of 'content analysis', though the distinction

between the two approaches is considered by many to be somewhat blurred (Braun & Clarke, 2006). The authors further describe thematic analysis of qualitative data as a process of reading (and re-reading) the data and, from this, identifying themes that stand out due to their apparent importance and/or their prevalence within the data set. This activity aims to identify patterns within the data and is largely inductive because the data informs the themes identified. It is, however, also acknowledged here that it is impossible to completely eliminate the researcher's own preconceptions, values, and beliefs from this process (Nowell et al., 2017; Walliman, 2010).

Content analysis, on the other hand, tends to be characterised by its emphasis on producing frequencies as an output; that is, the number of times each of the identified themes (or in some instances, keywords) appear within the data, rather than viewing the data in its context (Joffe & Yardley, 2004). However, one of the primary criticisms regarding the approach's objectivity is that, since the researcher is tasked with selecting, recording, and coding data, bias may occur (Bengtsson, 2016; Erlingsson & Brysiewicz, 2017). Additionally, such an approach is descriptive, but not necessarily explicative, unless respondents go further to expound on their answers.

The method employed in analysing the present study's data attempted to overcome some of the limitations of both content and thematic analyses. Namely, avoiding the possibility of trivialising the data and imposing a quantitative method of analysis and presenting qualitative data by simply producing frequencies, as per content analysis, (Silverman, 2011). That is, basing interpretations of the data on the impressions formed by the researcher and supported solely with selected examples from the data rather than a more robust and systematic handling

of the data. The analysis presented in this thesis adopted a predominantly thematic analysis approach.

This approach has also been adopted by other researchers, such as in the Audit Commission's Study of Recent Mothers (Audit Commission, 1997; Garcia, Evans & Reshaw, 2004), where free text comments were analysed by coding the comments into themes that emerged during the reading and re-reading of the data. the themes were then presented in the resulting report as frequencies with a narrative and illustrative quotes. In the absence of any real consensus over the best way to analyse and present the findings from open-ended survey questions (Garcia et al., 2004), it is hoped that this approach retains the context of the findings (through the descriptive commentary and illustrative quotes), while also ensuring that the relative prevalence of the issues is clear by presenting the frequencies.

3.2.6 Survey Limitations

The study's methodology is not without its limitations. First, due to the self-selecting nature of participants, there was no guarantee that all the participants met the criteria of being a psychologist or therapist trained in and using CBT. The study did not ask for the participants' credentials or qualifications. This could have an adverse impact on the findings as the data collected regarding the participants satisfaction with CBT techniques, the employment of existential thinking in their practices, and the theoretical underpinnings of their practices cannot be accurate or reliable if the participants had little to no practice experience. Yet, in order to minimise the probability of individuals not meeting the inclusion criteria, participants were recruited through the BABCP and it was made clear on the portal website and in the advertisement that participants had to be therapists or psychologists using and trained in CBT.

In addition to this, the methodological approach made it difficult to prevent certain groups from dominating the sample. For example, the sample studied may have all favoured CBT and not be representative of the views of all practitioners. It was hypothesised that any favourability in terms of representation could likely be attributed to professional compulsion to use CBT as supported by the NHS rather than a personal reverence for the approach. Another potential limitation was that while the newly designed scales were peer-reviewed by the researcher's supervisor and colleagues, the questions themselves were not pre-tested or piloted. A pilot study would have enabled respondents to comment on the nature of the questions and ensure that they are suitable in examining the proposed research questions. It would also enable weak and irrelevant questions to be identified and omitted from the study prior to data collection and analysis. In addition to this, the internal consistency and construct validity of the newly designed subscales were not investigated. This makes it hard to determine the degree to which the subscales measured what they aimed to.

3.3 Part 2: Interpretative Phenomenological Analysis (IPA) of Existential Attitudes in Cognitive Therapists ('qualitative strand')

The following sections discuss how one can choose and, more importantly, employ a qualitative methodology that provides the best fit to the study at hand. Specifically, the discussion examines the nature of IPA, including its argued benefits as well as criticisms, details the actual IPA steps taken to conduct this research, and contextualises IPA within and its suitability for this research project.

3.3.1 Choosing a Qualitative Methodology

For a topic such as the one under study which incorporated an online survey and face to face interviews, a mixed methods approach was found to be beneficial. As noted by Creswell (2010), and Migiro and Magangi (2011), there is a complementary relationship that is formed when pursuing a mixed methods approach that allows quantitative data to inform qualitative data, and vice versa. While the thrust of this research was focused on subjective meaning-making and interpreting nuanced experiences, it was nevertheless important, when possible, to be grounded by measurable and scaled responses that could be quantified. Given the larger sample these could be more readily generalised to the population at hand, if only to provide a meaningful link to the 'real world' of CBT within the NHS beyond the study and/or propose more measurable approaches towards effectively treating clients.

There are researchers in the social sciences that may prefer quantitative approaches, but studies investigating the quality of human existence typically demand more nuanced approaches that focus on description rather than quantification (Tuli, 2010). Qualitative research is not quite concerned with numerative aspects of experiences or with definitively pinpointing causal or correlative relationships (Berg & Lune, 2004). Rather, there is typically a desire to explore human nature by assessing how people derive meaning from their lives, specifically from their daily, interpersonal experiences (Berg & Lune, 2004; Creswell, 2013). Lune and Berg (2017) states, the "quality" in qualitative research "*refers to the what, how, when and where of a thing – its essence and ambience*" (p. 3). Qualitative research thus refers to the meanings, concepts, definitions, characteristics, metaphors, symbols, and description of things (Lune & Berg, 2017, p. 3).

The distinctions between quantitative and qualitative research methods can further be identified by assessing their epistemological roots (Lune & Berg (2017). To uncover these foundations, it is first important to contextualise the overall historical discourse regarding the differences between the quantitative and qualitative methods of research and, subsequently, their respective merits (Lune & Berg, 2017; Shenton, 2004). Quantitative approaches arguably do not reach the root causes or deeper issues of human existential and interpersonal phenomena such as relationships, which are key to the current research. Thus, a qualitative approach was also employed for this study because it provided an optimal fit by enabling the needed production of meaningful data (Elliot, Fischer, & Rennie, 1999).

In conclusion, while it was important for this study to adopt a mixed methods approach for reasons such as those previously discussed, this was still mainly a phenomenological study of subjective experience; it was, therefore, vital that the truths stemming from this work were explored in a qualitative manner.

3.3.2 IPA and other Qualitative Methods

The central aim of IPA, as espoused by scholars such as Smith and Osborn (2007) among others, is to allow researchers the opportunity to explore the lives of participants in depth so as to make sense of what goes on in their world. Unlike the central aim of ethnography, for instance, there is no real demand or desire to acquire inside(r) knowledge about a particular issue. Rather, there is very much a sense that all participants hold their own insider knowledge and can be invaluable sources of information from which one can better understand humanity at both the individual and collective levels.

IPA was chosen for this study because it allows for a comprehensive and interdisciplinary exploration of individuals as the "*cognitive, linguistic, affective, and physical*" beings that they are (Smith & Osborn, 2015). It does not partition, but rather unites the many parts of the human personality, existence, and essence. As Kay and Kingston (2002) and Smith, Jarman, and Osborn (1999) asserted, by engaging in an IPA methodology, researchers can become intimately familiar with the ideas, beliefs, and behaviours of those whom they seek to better understand. Thus, IPA can help explore the following questions and experiences: how existential elements were incorporated by the participants into their CBT practices; and how participants experienced their existentialist orientations and their integrative therapeutic approaches.

Prior to adopting IPA for this research, other qualitative methodologies were also considered. One of which was grounded theory, which employs an inductive approach towards data with the aim of drawing upon such evidence to theorise a phenomenon, instead of applying a theory to an investigated phenomenon and subsequently seeking supporting evidence, as most commonly done within a quantitative paradigm. But this can, arguably, be seen as a difficult approach when exploring phenomena that are still relatively under-researched, such as the integration of existential thinking in cognitive behavioural practices and techniques by cognitive behavioural therapists. While more research exists on the topic at present than it did a decade ago, the literature is still comparatively lacking, so attempting to use grounded theory for such a research endeavour would lack a solid foundation from which to then adequately relate findings with existing literature. Moreover, the aim was not necessarily to develop a theory, but rather to describe participants' experiences. Therefore, IPA seemed more suitable than grounded theory as its main 'currency' is "*the meanings, particular experiences, events, and states hold for participants*" (Smith & Osborne, 2007, p. 53).

Similarly, thematic analysis and narrative analysis methods were excluded from consideration. Even though there is certainly a "*thick description*" component involved in both methods which can be seen to resonate with IPA (Geertz, 1973), both methods historically have evolved from being more centrally focused on providing "*a research technique for the objective, systematic, and quantitative description of the manifest content of communication*" (Berelson, 1952, p. 18). In other words, they can be regarded as qualitative methods with a quantitative essence. Increasingly, such methods have developed into those that are concerned with both description and essence, but still place a greater emphasis on description and grouping of phenomena than on the essence of phenomena themselves (Cho & Lee, 2014). Unlike more 'mainstream' qualitative methods such as observations and case studies, in IPA it is important to focus on small sample sizes so as to prioritise giving voice to lived experiences at an intimate level, rather than in such a way that the meaning of data obtained is diluted in an effort to merely address issues related to sample size and representativeness (Creswell, 2013). This is because, although idiographic-oriented, IPA has been described as an approach that leads to specificity of information from a broader starting point; a zeroing in on the essence of experience (Lamiell, 1998; Windelband & Tufts, 1898).

IPA is thus an approach less burdened by the demands of representativeness because it does not claim to present unifying truths; rather, it seeks to present truths as assessed by individuals as they assess their worlds, with assistance when needed (Englander, 2012). At the most, it generalises results to the investigated phenomenon as experienced by an individual or a small group. Therein lies the approach's ability to remain flexible, exploratory, and descriptive, in addition to emancipatory for those participants whose stories are told.

In addition to this, there is also a sense that IPA is not merely a linear method of going from A to B in terms of understanding phenomena from a detached standpoint, with the aim of minimising bias. Instead, from an IPA viewpoint, more is accomplished when the researcher accepts and explores the potential of participating in the data collection and interpretation processes. The interviewer and/or researcher's participation stems from the deep and prolonged level of interpersonal engagement that occurs during the interviewing and analysis process, something that resembles the rapport that can be established between clients and therapists. This can provide for more illuminating insights about what participants go through in their day-to-day lives, something on which they are experts and also something that can, in many cases, be effectively conveyed through the storytelling skills of the researcher. That is, IPA is a "*dynamic process with an active role for the researcher in that process*" (Smith & Osborne, 2007, p. 53).

In this sense, IPA also focuses on the 'double hermeneutic' by assessing the subjective world and experiences of both the researcher and the participant. These two standpoints are foundational to understanding the world of the participant (Smith & Osbourn, 2008), as described to and by the interviewer/researcher. Additionally, there is a sense of looking at phenomena in a bi-directional rather than unidirectional manner. That is, looking at phenomena from both the participant and researcher's perspectives as a means of attaining mutual or deeper understanding.

The interpretative aspect of IPA can be approached in one of two distinct manners: to understand the subjective world of participants in a manner that truly treats participants as experts of their own internal worlds, thus giving their reflections highest priority in the same manner an advocate would; or to understand their subjective world whilst also being mindful

of information and phenomena that participants may not see because they are essentially too close to the subject themselves to be their only adequate and grounded storyteller (Englander, 2012).

In sum, IPA, the ideal method of choice, can provide a greater understanding of how CBT therapists give meaning to existentialist therapeutic approaches and techniques, as well as to their integration within their CBT therapies and therapeutic relationships. The following section provides a reflexive account of the researcher's own process of engaging with this flexible and descriptive method.

3.3.3 Using Semi-Structured Interviews for IPA

For this study, semi-structured interviews were conducted with eight practitioners to collect data about their experiences as accredited cognitive behavioural therapists in addition to their use or attempted use of existential elements in their daily practices. IPA was utilised both as data collection and as the data analysis method.

IPA often employs interviews, particularly semi-structured ones, because they provide a communication medium through which to deeply examine phenomena in the most personal and interactive manner, in contrast to an activity such as journal or diary writing (Smith, Jarman, & Osborn 1999). Furthermore, semi-structured interviews allow respondents space to exist with their answers. A survey, for instance, confines one to the paper on which it is written, but an interview provides room for respondents to articulate their thoughts, tangentially and tentatively if needed. There is room to explore.

IPA is partly driven by symbolic-interactionism. This is the idea that in order to adequately reveal a person's subjective world, a researcher must engage with the oral communications offered. Keeping an open mind to the fact that pertinent information regarding individuals' experiences can exist in straightforward as well as non-linear ways by which information is hidden and can only be revealed through an iterative process of interpretation (Denzin, 1995).

The primary reasons why semi-structured interviews are particularly useful within an IPA approach is that they allow for comfortable rapport building with participants, the collection of highly complex or nuanced valid data, and the use of complex questions. In particular, the ability to instil a sense of both trust and empathy is important to the exercise of data collection and was especially important in this study (Kvale, 2006). Whilst trust can make participants feel more comfortable discussing various matters and answering diverse questions, empathy is needed and must be sufficiently demonstrated by the researcher for participants to feel that their time is not being wasted and they will be respected if they do choose to open up and relay information in confidence. It has been argued that if participants believe that the researcher will try to understand their perspectives on a sincere level, as opposed to cold and manipulative data extraction, the information will ultimately be shared more freely, which will enhance the research process (Kvale, 2006).

Moreover, when conducted with sincere empathy, semi-structured interviews can motivate a reflexive, 'organic' question and answer/discussion process, thus leading to breakthroughs based on the comfort and goodwill of the individuals involved, rather than on power dynamics that may manifest in other data collection methods. That is, the flexibility of semi-structured interviews is regarded as a critically important benefit brought along to the IPA process because it allows both interviewer and interviewee to be led by the discussion to potentially unforeseen

aspects, thereby producing richer data regarding the essence of that participant's lived experiences of the investigated phenomenon.

Thus, the data collected is arguably not only deep and abundant, but also authentic because it has arisen from what the participant and researcher perceive as a mutually beneficial relationship. This relationship facilitates a sense of (appropriate) intimacy and potentiates deeper understanding and knowledge about the phenomenon.

3.3.4 IPA Interview Research Procedure

Following recruitment via the BABCP, participants were first asked to choose where they would like to hold their respective interviews, both for practical purposes as well as to establish a sense of rapport and ensure that their participation did not feel forced or the product of an uneven professional exchange (Gemignani, 2011). Indeed, ensuring rapport early on was found to be critically important, principally when the addressing issues which create psychological vulnerabilities for both researcher and participants, such as arguably those concerning 'meaning of life' issues, particularly when discussed with participants of a more advanced age (Gemignani, 2011).

Participants were interviewed in their homes, workplaces, and, in one case, a hotel meeting room. Each setting had its benefits and its drawbacks. With respect to interviews conducted in homes, there was a definite level that meant participants were, to use the term, 'in their element'. Even if neither they nor the researcher were initially aware of the power of conducting interviews in a home setting, upon further inspection it became clear that by interviewing in such an environment, participants could become more engaged than if they

were in a more sterile and professional environment that lends itself to more calculated reasoning rather than self-expression and reflection. While professionalism in such interviews and studies is important, the crux of this research did not pertain so much to professional issues but to the intersection between the personal and the professional, and how that translated in terms of whether participants found it meaningful to integrate components of existentialism into their practices.

Interviewing some participants in their homes was very beneficial in that it facilitated the achievement of such an intersection. The flip side of the coin was that home interviews were also limiting because, by being too much 'in their element', participants tended to be much less inhibited. This appeared to translate into qualitative data which, whilst insightful, tended to be more abstract and plentiful than the more grounded and manageable data obtained with those who were interviewed in their workplaces and hotel meeting room. In the latter instances, the primary benefit of such settings was that they were in locations that were comfortable and convenient for the participants, which encouraged them to be more forthright than if they had been in less comfortable surroundings. However, in contrast to those interviewed in their homes, there appeared to be a bit more rigidity in their answers than could have been obtained in a home setting.

Once the interview location and schedule was set, the researcher and each participant met for approximately one hour to conduct the semi-structured interviews. At the beginning of each interview, the researcher informed each participant of the nature of the study, they provided a brief overview of the types of questions that would be asked so as to introduce the subject matter. The interviews were audio recorded to ensure the integrity of the conversations documented. The recorded interviews were complemented by the researcher's detailed note-taking throughout each interview in order to capture participants' gestures and mannerisms.

3.3.5 Interview Questions

Given the nature of this study, the exact questions posed to each of the participants varied slightly. Divergences occurred when participants' responses invited the researcher to ask follow-up questions that were unique to the experiences of that individual. The interview schedule was customised to allow participants space to sufficiently express themselves as different ideas and emotions affected them. The blueprint questions asked were as follows:

Q1. What is it about the existential dimension that attracted you to use it in your therapeutic work?

Explanation: It was already established at the recruitment stage that the participants were, on some level, attracted to existentialism. This question sought to further examine the reasons behind this attraction. Specifically, if this was merely reactional, i.e. a reaction to the routine and arguable failures of CBT, or whether there were deeper and/or more personal reasons for being drawn to existential approaches.

Q2. What aspect of the existential approach do you think is missing from CBT?

Explanation: This question was asked because it seemed to be a natural extension of the first question, seeking specifically to isolate what was missing from CBT that could be gained from existentialism.

Q3. How does the existential approach influence your application of cognitive therapy?

Q4. In what ways do you actually use existential ideas in your clinical work and how is it different from cognitive therapy as usual?

Explanation: The latter two questions were asked in order to better understand not only what made participants gravitate towards existential approaches, but the specific ways in which they incorporated existential elements into their cognitive therapy approaches.

Q5. So, what's your experience of integrating an existential dimension into cognitive therapy?

Explanation: Moving away from a need to identify the methods of integrating existentialism into CBT, this question was posed in order to better understand or link such integration with the results it produced for participants and their clients.

Q6. How could you teach a CBT-er to consider CBT in an existential way?

Explanation: This question was posed in order to elicit participants' ideas on how best to disseminate information and helpful tips about disseminating a hybrid CBT-existential approach throughout their professional communities.

Q7. Do you feel that there are any presenting issues that respond better to a cognitive approach that is aware of ET? Is there any kind of presenting issues or clients that respond better to that?

Explanation: This question was asked in order to assess whether participants believed there were particular types of individuals or problems that would benefit from existential elements more than others, based upon personal traits or particular experiences or diagnoses. Thus, the question was meant to explore optimum ways of customising an integrative approach for individual clients.

Q8. How would you advise clinicians to incorporate the existential approach into cognitive therapy?

Explanation: This open question was more concerned with eliciting participants' opinions about the type of counsel they could offer colleagues in terms of optimising integration and use of a hybrid approach with clients. Thus, this question was concerned with therapist-therapist counsel dynamics rather than with the therapist-client counsel dynamics.

3.3.6 Analysis: IPA Data Analysis Steps

The IPA data analysis followed a series of steps to ensure the soundness of the interpretation, as recommended by Smith, Flowers, and Larkin (2009). These steps included reading and then re-reading the written transcripts (the transcriptions were carried out by a professional agency) from the interviews. This data immersion spanned the course of four and a half months, time which allowed the researcher to repeatedly revisit the data in order to extract themes and pertinent information with which to best frame participants' narratives.

Parallel to this process of data immersion was the process of note-taking, which occurred throughout the interpretative endeavour. By taking copious notes, the researcher ensured that descriptive, linguistic, and conceptual observations were registered. The aims of such process were: 1) to ensure that the researcher maintains an objective approach and catalogues information as it is revealed through text and as he or she reacts to it; and 2) to bolster the chances of having the researcher connect with the narratives so as to ultimately frame the most illuminating presentations of the participants' experiences. This was achieved by developing a set of descriptive comments as written out in the margins of the interview transcripts and then transferring such comments into Microsoft Word to create an electronic record.

With respect to the notations on various types of comments, linguistic comments described the nature of participants' answers, including how they used language to convey their answers. Conceptual comments were centred on emergent themes concerning how the participants' understood their experiences and perceived them. Descriptive comments simply characterised and summarised participants' narratives or the way these were constructed in a way that tried to remain as faithful as possible to the original text. Lastly, an examination of the comments produced in the previously described step led to the formulation of emerging themes.

The combined research methods chosen allowed for the double hermeneutics to shine through but also points at how complicated the process is. Since the researcher was so immersed in the data and different avenues for interpretation that the task, whilst rewarding and informative, was in many ways exhausting.

3.3.7 Critiques of IPA and Limitations in this Research

Whilst IPA can be a beneficial approach, as any other method, it is not infallible. This section provides some of the common criticisms of this method and the specific limitations that arose through its use in the context of this research.

To begin, since IPA focuses on investigating and exploring participants' experiences, especially in an immersive and iterative manner, a primary criticism of the approach is that researchers can become so involved in the data that they lose objectivity. While the researcher's purpose within IPA is to tell participants' stories, it is still necessary to do so in a methodical and objective manner. IPA can arguably blur the line between immersion and 'becoming lost' in the data. One can debate the merits of how exactly a researcher can become lost, but the primary concern is that "*access depends on and is complicated by the researcher's own*

conceptions... required in order to make sense of that other personal world through a process of interpretative activity" (Smith, Jarman, & Osborn, 1999, pp. 218–219).

This, in turn, leads to another critique, that IPA diverges from more often used qualitative methods, such as those with ethnographic or narrative designs as it demands greater reflexivity and consciousness on the researcher's part to ensure that they are not attributing their beliefs, thoughts, and feelings to the participants' narratives (Creswell, 2013). While this is a concern with any qualitative methodology, it is arguably more pronounced with IPA than other approaches because IPA is so centred on a constant, routine, and prolonged immersion in collected data by which the demarcation between the participants' beliefs, thoughts and feelings can conceivably become entangled with one's own (Hein & Austin, 2001). It should here be noted that the researcher's reactions are not to be ignored or stifled, but merely that they must be suspended until later in the analysis in order to ensure the authenticity of the collected data (Hein & Austin, 2001).

Data immersion and lack of objectivity are two aspects which can be regarded as limitations and as contributing to faulty, unfaithful, and biased findings or interpretations. IPA's flexibility and fluidity, as well as the interpretative expansiveness thereby allowed, is another aspect which can bear the same effect. In response to this, it has been argued that it is not only advisable but necessary that IPA studies have independent reviewers with whom researchers can periodically ensure their objectivity. The current researcher's supervisor and colleagues fulfilled this role of assuring the quality and objectivity of the work. This was guided by several meetings to discuss the process of developing themes and checking that the coding appeared correct. This can arise especially in studies in which there is no outside reviewer to ground the researcher and, if needed, help them find equilibrium if it needs to be restored.

In addition to this, in order to limit this potential risk, the researcher learned the nature, history, and particulars of IPA, and the various ways in which it can be conducted (Smith, 2011). Specifically, this pertained to how notes about the interviews, interviewer, and interviewee gestures, thoughts, etc. are to be written in the margins of transcripts during the review and analysis stages. Such procedure creates a clearer record of the evolution of the researcher's thinking, both with respect to the investigated phenomena and, parallel to this, the evolution of the researcher's worldview as a result of conducting such interviews. This then creates a clearer delineation between the researcher's own thinking/biases and what participants actually said (Smith, 2011). It also helps to ensure that what takes centre stage are not any faults of the interpretative process but, rather, the narrative accounts offered by participants. That is to say, IPA can enable the researcher to stay "*true to their study aims, to the experiences of participants and to the richness of participants' accounts*" (Dunne & Quayle, 2001, p. 99).

Another major criticism of IPA is the extent to which a researcher can obtain sufficient data to analyse depends on the articulateness of the study's participants. Fortunately, as the participants in this study were professional CBT therapists, they were quite verbose. However, if participants are by some means impeded in providing their experiences in an intelligible manner that further is true to form, the researcher is only able to take away moderately accurate fragments of the participants' experiences. This will then impact the researcher's ability to engage in the double hermeneutic process and, subsequently, undermine the purpose of IPA (Hein & Austin, 2001). This may also be seen as linked to the fact that probing human experience at the level of subjective meaning is, in itself, a complex venture given that psychology researchers cannot enter the minds of those whose behaviour, ideas, and emotions they are studying (Shenton, 2004). Irrespective of technological advances in brain imaging and

understanding anatomic structures and their relationships with human affect, psychosocial and social science inquiry must dig deeper to ensure that what researchers believe is being discovered is true to form, and not unduly distorted by the researcher or participant.

Researchers can also remain grounded by methodically tracking their own reactions and interactions with the collected and analysed data throughout the iterative process, so as to monitor changes in their perception and assess any static rather than fluid thinking that may be suggestive of a stall or distortion in the interpretative process. This can be more arduous than having a reviewer, but it has historically been the case that researchers cannot depend upon help from peers alone in order to do their work. Peer mentorship is available as a complementary tool but is arguably not a requirement for fruitful, independent study. Self-sufficiency is critical, and thus must be developed through constant problem solving, as suggested herein. This was achieved by the lead researcher having to rework the IPA many times over a period of 12 months, to refine and eliminate bias within the IPA.

3.4 Summary and Conclusion

The key concerns of this research were: 1) To test the hypothesis: As ‘existential thinking' increases, satisfaction with CBT decreases; 2) To determine CBT therapists’ satisfaction with CBT; 3) To better understand CBT therapists’ perspectives on incorporating an existential component within CBT practice; 4) To explore the experience of accredited CBT therapists in the use or attempted use of existential components in their practise of CBT; and 5) To understand how these existential components were incorporated within CBT.

To address these above questions, two data collection methods were used. The online survey questioned participants as to their personal and professional viewpoints relating to the

incorporation of existential thinking and practice into cognitive behavioural practices and techniques. More specifically, the multitude of items presented in the online survey inquired, much like the questions in the semi-structured IPA interviews, the nature of how such integration should occur, within the parameters of that which could be achieved using a quantitative-based instrument. The individual face-to-face interviews specifically questioned participants about their thoughts on the main concerns of this research, outlined at the beginning of this section.

Another methodological difference mentioned by several participants was that the IPA interview process led to a sense of empowerment among all parties, enabling them to feel as if they were part of something greater than a study limited in its ability to add original contributions to the field. They were able to be part of something that would ultimately lead to great strides for the field, something that would have been lost if in-depth interviews were not utilised. Online surveying did not appear to accomplish such.

The more truncated inquiries were limited to the online survey. It is argued that brevity would have defeated the purpose of online surveying, which was obtaining meaningful numeric data and complementing the more descriptive and qualitative data of the individual interviews. The individual, in-depth interviews were more involved than those presented online. It is important, however, to note that the phenomenological conclusions of this study are informed, in equal part, by the data obtained by both methods. Both the survey and interviews were integral components of information gathering.

Chapter 4 – Analysis/Discussion: CBT Satisfaction and Existential Thinking Survey ('mixed strand')

4.1 Introduction

One of the central, if not overarching, points or objectives of psychotherapy is to assist individuals with living better and healthier lives, which can be achieved in various ways (Norcross, 2002). Additionally, the improvement of a client's quality of life is to be not only assessed by traditional mental health standards but also, and perhaps more importantly, in a holistic or total health manner. However, there is also another underlying point of psychotherapy, which is that there is no one-size-fits-all therapeutic approach (Norcross, 2002). Since individuals are unique, they require uniquely tailored approaches (Norcross, 2002). This does not mean that similarities between individuals preclude specific techniques from benefitting groups of people. The argument is that within the use of specific techniques, some people will thrive and others will not. This mandates that therapists must be attuned to the specific needs of each client (Norcross, 2002).

Recent empirical research and anecdotal evidence suggests that, as is relevant to this study, CBT is not the best therapeutic approach for all clients (Johnsen & Friborg, 2015). Such can be said of virtually any therapeutic method, because each individual must find a best-fit approach that works for them. That being said, CBT in particular has been found to have limitations in a number of areas including the fact that it can be too regimented, too relaxed in being permissive of clients who decline to not face their issues head-on, and ineffective when dealing with individuals of diverse racial/ethnic and cultural backgrounds (Rathod et al., 2010). In the same manner that individuals are unique, practitioners are tasked with constantly remembering that, as individuals, their clients must be treated as autonomous and distinctive people who cannot all merely be

treated with a CBT approach as if they were the same. The reasons explicating why CBT is not best for all clients vary, but common rationales include the complexities incurred via the myriad combinations of the age, gender, learning style, ethnicity, cultural, religion, etc. of clients as previously alluded (Cardemil, Reivich & Seligman, 2003; Rathod et al., 2010). Hence, the benefit of having numerous therapeutic approach contributions has been introduced into the field of psychology over the last century.

With this in mind, the inspiration of this study was to look at the potential to bridge any gaps or impediments to the development of a more comprehensive treatment plan, and to explore the range of possibilities concerning the benefits of integrating CBT and existential therapy (existentialism) based on the preliminary understanding and belief that CBT alone is inadequate to sufficiently assist many individuals who seek meaningful psychotherapy, especially concerning issues that involve the major questions or milestones of life and the human condition. More specifically, it was the aim of this research to: explore whether, as therapists became more involved with and learn about existentialism, their satisfaction with CBT would decrease; whether therapists are, in fact, satisfied with CBT practices as they stand at present; and to grasp a better understanding of therapists' willingness and thoughts on incorporating existential elements or components into their CBT-oriented practices. Thus, the focus of this study has been not to juxtapose CBT and existential therapy (existentialism) as if to suggest stark differences and seek a way to bridge the gap between them. Rather, the focus has been on comparing the two to examine the modes in which they already, in certain ways, mirror each other in approach and intent.

In pursuing this research, the main research question was: 'Why might cognitive behavioural therapists consider existential ideas in their work?' Whilst this will be discussed in depth at a

later point, the results of the current study's online survey were illuminating and indicative of the proposition that CBT and existential therapy have more in common than not. As this chapter will discuss, the online survey results suggest that the two can be integrated to better engage and treat clients, but that more training is needed to instil CBT therapists with existential ideas.

This chapter first recaps the methodology and leading questions behind the online survey questionnaire, explaining how this was constructed and how the analysis was conducted. It then presents the key findings from each of the three survey scales in turn, alongside a discussion of each. This is followed by an examination of the correlations between the scales and their implications. The chapter concludes with a summary and critical reflection on the survey findings.

The following Chapter 5 will present the results of the four open-ended questions which were part of the online survey and an integrated discussion of the online survey as a whole.

4.1.1 Online survey questionnaire: scales and analysis

The first component of the data collection for this study involved the online survey questionnaire which, in many ways, served as the grounded means of understanding the deeper qualitative and subjective data from the individual interviews of the IPA study.

As detailed in the methodology chapter, the survey questionnaire was completed online by participants. It aimed to assess the extent to which they were satisfied with CBT and the ways in which they found the approach to be perhaps lacking, and thus require or would benefit from integrative approaches, such as with existentialism. The participants were all psychologists or therapists that were accredited or eligible for accreditation by the British Association of Behavioural and Cognitive Psychotherapies (BABCP). As such, their daily or routine

interactions with clients relied on the skillsets resulting from the CBT approach. Thus, the survey allowed the researcher to extract meaningful data from people with expertise regarding how the approach holds up to scrutiny on a number of levels. The survey had three objectives:

1. To determine and measure CBT therapist satisfaction with CBT.
2. To test the hypothesis: As 'existential thinking' increases, satisfaction with CBT decreases.
3. To better understand CBT therapists' perspectives on incorporating an existential component within their CBT practice.
4.

The online questionnaire consisted of three scales with a total of 23 items. These scales are as follows: Scale of CBT Satisfaction (CBT-S) (8 items), Scale of Existential Thinking (SET) (11 items), and Scale of CBT with an Existential Dimension (CBT-E) (4 items). The combined ratings for each scale and sub-scale show the magnitude of that variable. The higher the rating, the stronger the respondent endorses the item statement. The following two items on CBT-S are reverse scored: '*I have in the past guided therapy away from big issues*' and '*I integrate other approaches*'. Each scale and sub-scale was analysed via a variety of descriptive and inferential statistics (e.g., variability, correlations and reliability) using the Statistical Package for the Social Sciences (SPSS) version 21. This chapter reports the results of these analyses for each scale and each item.

4.1.2 Scales' internal consistency

Cronbach's coefficient alpha was adopted as a measure of the scales reliability, indicative of the consistent, dependable, stable, and predictable results (Iacobucci, & Duhachek, 2003). This measure "*represents the theoretical average of all potential split-half reliability estimates*

among a set of item scores. The coefficient alpha is calculated when item response formats are multiscored (e.g., Likert-type scales)" (Bardhoshi, & Erford, 2017, p.258). The rule of the thump is "*α < 0.5 for low reliability, 0.5 < α < 0.8 for moderate (acceptable) reliability, α > 0.8 for high (good) reliability*" (Ekolu, & Quainoo, 2019, p.25). Under more conservative approaches, α > 0.7 is viewed as acceptable (Nunnally, 1978)

SET is an 11-item scale constructed as based on a series of studies, in which "*internal consistencies ranging from a =0 .88 to a =0.94"* (Allan & Shearer, 2012, p.24) were found. In the present study, its Cronbach's coefficient alpha was *a =0* .93. This is indicative of high internal consistency, quite satisfactory reliability, and merely 7% of noise in data (Iacobucci, & Duhachek, 2003), and minimal odds of random errors, such as those derived from lucky guessing (Nunnally, 1978).

On the other hand, the CBT-S and CBT-E scales were created purposefully for this research. The Cronbach's coefficient alpha of the CBT-E was *a* = 0.85, and removing any of its items would decrease the scale's reliability. Its four items thus showed rather high reliability. As for the CBT-S, its Cronbach's coefficient alpha was *a =0*.68. Nevertheless, the recommended removal of the reverse score item '*I integrate other approaches'* from the scale increased the Cronbach's coefficient alpha to *a* = 0.72. No other item was recommended for deletion to increase the reliability of the scale. Therefore, a seven-item scale, of acceptable, but not remarkably high internal consistency, was embraced for use in subsequent data analysis testing.

As discussed by Bardhoshi, & Erford, 2017, p.257), "*all other things being equal, the more items on the test, the more reliable the score*s." It has even been suggested that scales should have "*the required minimum number for internal consistency measurements*" (Ekolu, &

Quainoo, 2019, p.25). Then, it is possible that the small number of items in CBT-S might have contributed to lower reliability alphas. Yet, this was definitely not the case of the CBT-E, which showed good reliability even with a small number of items.

Cronbach's coefficient alpha seemed more adequate than the reliability indicators coined 'test-retest' and 'alternative forms', which involve longitudinal approaches and the application of the same, for test-retest, or construct-equivalent, for alternative forms, measures in two different moments in time (Drost, 2011). It was also found more adequate than the 'split-half', is the statistical origins of, less powerful than Cronbach's coefficient alpha, and is "*usually cheaper and more easily obtained than over time data*" (Drost, 2011, p.110).

4.1.3 Validity, and other trustworthiness considerations

In the present study, two surveys were developed. CBT-S aimed to assess therapists' satisfaction with CBT, and CBT-E intended to measure therapists' past, present and future willingness to use of meaning-based approaches. In contrast with reliability, which assesses whether, all things remaining equal, the adopted measure would give consistent results, validity targets the extent to which the instrument assesses what it intends to assess.

There are many aspects to validity. "*Construct validation is involved whenever a test is to be interpreted as a measure of some attribute or quality which is not 'operationally defined'*" (Cronbach, & Meehl, 1955, p.282). Said differently, it covers the relationship between the concept one seeks to assess, and the measure used to assess it (O'Leary-Kelly, & Vokurka, 1998). Although often ignored, its discussion is critical whenever the concept is evaluated through a qualitative measure, such as with the case of survey-based studies.

Two types of construct validity are: content validity, which is generally deductively "*established by showing that the test items are a sample of a universe in which the investigator is interested*" (Cronbach, & Meehl, 1955, p.282); and face validity, which is a subjective evaluation of whether items of a survey or variables appear to be measuring what they are supposed to be measuring. In the present study, these were inspected by the author's supervisor and peers. This analysis suggested that both surveys were perhaps a bit wordy. Yet, each one of the items CBT-S seemed to assess satisfaction, including satisfaction in general and satisfaction with specific aspects of the approach. It also revealed the scale apparently targeted several dimensions, such as the comprehensiveness and value of CBT's tools across diverse situations, and their need to turn to alternative approaches. As for CBT-E, it seemed to focus on past, present and future willingness or experience with the use of meaning-based approaches.

Both scales, and SET, adopted as measures Likert-like scales. These variables "*typically violate the assumption of normality necessary for parametric tests. The ordinal scale also violates the frequent assumption that data are from a continuous distribution*" (DePuy, & Pappas, 2004, p.1). As a consequence, medians and quartiles are the recommended measures of central tendency, principally when the sample is small (e.g., Boone, 2012; Fagerland, Sandvik, & Mowinckel, 2011).

Moreover, being variance conditions met, for hypothesis testing, nonparametric tests are generally preferred (e.g., DePuy, & Pappas, 2004; de Winter, & Dodou, 2010), with some controversy (Mircioiu, & Atkinson, 2017; Norman, 2010). The use of nonparametric tests for group comparison purposes involves detecting statistically significant differences in the distribution of data (e.g., Nachar, 2008), rather than differences in measures of central

tendency, such as means. The nonparametric tests that were more commonly employed here were Spearman's correlation coefficients, suitable for large and non-normally distributed populations (Arndt, Turvey, & Andreasen, 1999).

When the number of items in a survey, and/or the sample size is large, means are often employed as measures of central tendency (Fagerland, Sandvik, & Mowinckel, 2011). This choice is particularly less controversial when applied the descriptive and inferential analysis of sums of Likert-like ratings, or survey's total or overall scores. These variables can be regarded as discrete quantitative variables (e.g., Fagerland, Sandvik, & Mowinckel, 2011). It is posited here that, theoretically, the concurrent validity of CBT-E could be demonstrated by positive correlations of its items and overall scores with SET's items and overall scores, which is a validated measure. This aspect will be inspected in more detail when discussing results.

4.2 Sub-scale Analyses

4.2.1 Scale of CBT Satisfaction (CBT-S)

The questions here assumed that respondents were already using CBT and that an existential approach would supplement the traditional CBT approach. Respondents were offered the opportunity to rate each item on a five-point scale ranging from *'strongly disagree'* to *'strongly agree'*, with a neutral rating option. Regardless of item statement, whether stated positively or negatively, a 5 rating is always high and a 1 is always low for that variable. There is one item ('*I have in the past guided therapy sessions away from big issues*') that was reverse scored.

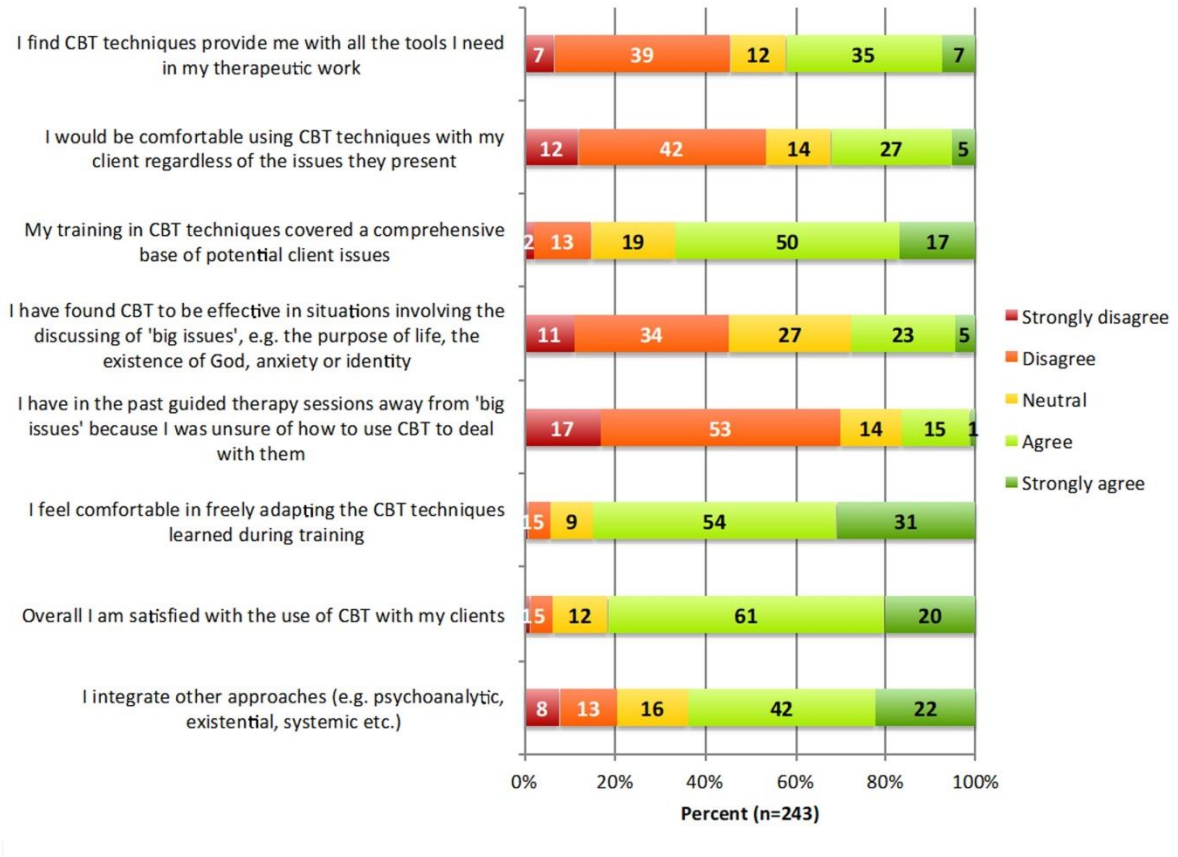

Figure 1 Summary of frequency CBT-S

The results, as seen in Figure 1, show that 85% of the 243 respondents *'feel comfortable in freely adapting the CBT techniques learned during training'* which has a mean rating of 3.94 and the lowest standard deviation of .79. In addition, 81% of respondents indicated *'overall satisfaction with the use of CBT with my clients,*' which had a mean rating of 3.69 and a standard deviation of .96. However, four items had less than 1 SD and the other four were barely above 1 SD, meaning that the respondents rated each of these items very much alike. Table 2 provides these results in detail.

Table 2 Scale CBT-S: Item Statistics

Item		Mean	SD
1	I find CBT techniques provide me with all the tools I need in my therapeutic work	2.97	1.14
2	I would be comfortable using CBT techniques with my client regardless of the issues they present	2.72	1.14
3	My training in CBT techniques covered a comprehensive base of potential client issues	3.66	0.97
4	I have found CBT to be effective in situations involving the discussing of 'big issues', e.g. the purpose of life, the existence of God, anxiety or identity	2.75	1.06
5	I have in the past guided therapy sessions away from 'big issues' because I was unsure of how to use CBT to deal with them	4.09	0.81
6	I feel comfortable in freely adapting the CBT techniques learned during training	3.94	0.79
7	Overall, I am satisfied with the use of CBT with my clients	3.69	0.96
	Average Mean	3.28	

From these results, it is clear that respondents were generally very satisfied with CBT as a therapy for addressing the issues that their patients present, with 81% of respondents agreeing/strongly agreeing that they were satisfied with their use of CBT with their clients (item 7). While the number of respondents who noted that CBT offered all of the necessary therapeutic tools was not majority-based (42%, as per item 1), there was a general concordance that CBT is beneficial in terms of engagement and the usefulness of therapeutic tools. Despite this, a sizeable proportion (64%) of respondents agreed/strongly agreed that they either already had considered, or actively were considering, incorporating existential or meaning-based therapies into their work with clients (item 8).

4.2.2 Discussion of CBT-S

Overall, the CBT-S scale shows that the majority (85%) of survey respondents were satisfied with CBT as a stand-alone technique (item 6). In short, it was seen to get the job done. Whilst respondents were generally satisfied with CBT, the survey responses also indicate their openness to modifying and integrating supplemental techniques, such as an existential or meaning-based therapy. It should also be stated that CBT was believed not only to accommodate supplemental techniques, but arguably to allow for techniques that augment CBT elements (this will be further discussed in the following chapter). Thus, there is a strengthening rather than layering quality that the respondents attributed to CBT, demonstrating one rationale for respondents' satisfaction with CBT as a technique. This was further addressed when they were asked about their comfort levels in terms of thinking about and integrating other approaches, as is discussed below.

4.2.3 Scale of Existential Thinking (SET)

This part of the survey measured respondents' personal use of, or belief in, concepts associated with existential thinking. For this scale, respondents were asked to score each item on a six-point scale ranging from *'no or rarely'* (rated 1) to *'all the time'* (rated 5), with a neutral rating option also included ('*don't know*').

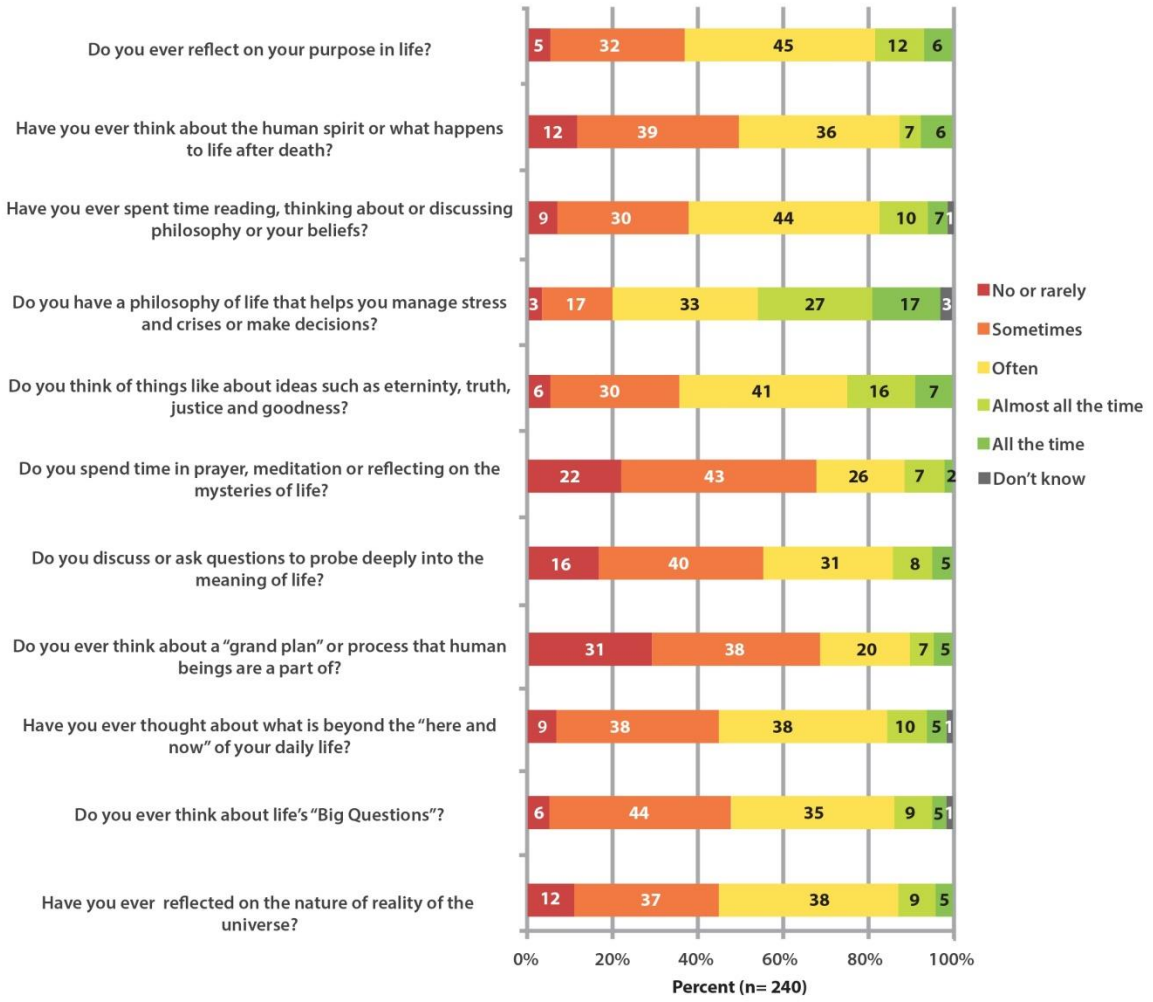

Figure 2 Summary of frequency: SET

As Figure 2 illustrates, the highest respondent rating, 77% ('often', 'almost all time' and 'all the time') of respondents, in this set was for the item suggesting that they have '*a philosophy of life that helps them manage stress, manage crises or make decisions,'* with a mean of 3.46 (table 3) and the highest standard deviation of 1.11. This means that not only did more respondents rate this item as the highest, but also that there was a relatively high level of variation across this question. The next highest rated item, at 64% ('often', 'almost all time' and 'all the time') of respondents was thinking *'about ideas such as eternity, truth, justice and goodness,'* with a mean of 2.87 and a standard deviation of .97 (Table 6). The lowest rated item

was *'thinking about a "grand plan" or process that human beings are a part of',* with a mean of 2.16 and a standard deviation of 1.07. This suggests that practitioners might be more inclined to a personal philosophy that works for them and includes thinking about higher order existential issues, but does not necessarily require a "*grand plan".* Table 3 provides the statistical SET results per item.

Table 3 Scale SET: Item statistics

Item		**Mean**	**SD**
9	Do you ever reflect on your purpose in life?	2.81	0.93
10	Do you ever think about the human spirit or what happens to life after death?	2.54	0.98
11	Have you ever spent time reading, thinking about or discussing philosophy or your beliefs?	2.76	0.99
12	Do you have a philosophy of life that helps you manage stress and crises or make decisions?	3.46	1.11
13	Do you think of things like about ideas such as eternity, truth, justice and goodness?	2.87	0.97
14	Do you spend time in prayer, meditation or reflecting on the mysteries of life?	2.25	0.93
15	Do you discuss or ask questions to probe deeply into the meaning of life?	2.46	1.00
16	Do you ever think about a "grand plan" or process that human beings are a part of?	2.16	1.07
17	Have you ever thought about what is beyond the "here and now" of your daily life?	2.65	0.97
18	Do you ever think about life's "Big Questions"?	2.64	0.95
19	Have you ever reflected on the nature and reality of the universe?	2.55	0.96
	Average Mean	2.65	

4.2.4 Discussion of SET

It can be argued that, as is indicated by the current results, most respondents held to a philosophy that helped them to manage stress and make decisions. Furthermore, most thought about or discussed philosophy and/or their beliefs, which is not surprising; it may be expected that a therapist who addresses these issues with clients would also be conversant with the issues on a personal level. However, it should also be taken into account that therapists must always be circumspect about not imposing their own thinking on the client so as not to exert control over the patient (Prochaska & Norcross, 2009). This is particularly true in regards to meaning-based concepts. Even so, an interesting trend can be discerned here whereby a dissonance exists between acknowledging the habit of thinking deeply about one's life purpose (item 9) and related issues, and going further by actually asking deep questions into the meaning of life (item 15), which 56% of respondents marked as 'rarely or sometimes' present. Such a dissonance, speculative at this stage though it may be, begs the question of whether or not there may be a connection between the ability to superficially address existential questions and a lack of taking further steps to explore and answer such questions when they are raised by clients who are actually struggling with existential and non-existential issues. That is, is the lack of existential integration, in some respects, a sense of therapist-client and client-therapist mirroring? The following section explores this possibility by examining respondents' attitudes towards integrating an existential dimension into their CBT practice.

4.2.5 Scale of CBT with an existential dimension (CBT–E)

While Questionnaire 3 (CBT-E) from which this scale was derived stands on its own, it should be partly assessed in comparison with Questionnaire 2 (SET). The CBT-E scale consists of four items that measure the respondent's propensity or inclination to integrate CBT with

existential thinking and employs the same variable ratings as the CBT satisfaction scale. Figure 3 illustrates the distribution of responses to these items.

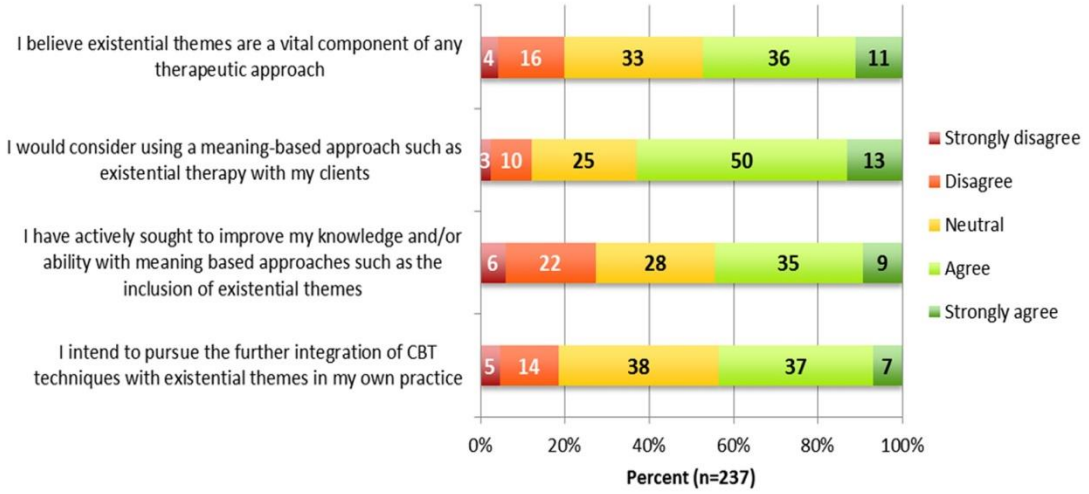

Figure 3 Summary of frequency: CBT-E

The majority of respondents expressed agreement with the added value of integrating CBT and existential thinking (Table 7, items 20, 21). Many of them either already had integrated, or intended to integrate, CBT and existential thinking into their practice, including obtaining additional training in order to do so. The highest rated item, 63% of respondents, in this scale was *'considering using a meaning-based approach such as existential therapy with my clients',* with a mean of 3.61 and a standard deviation of .92. The second highest rated item *'I believe existential themes are a vital component of any therapeutic approach'* (M = 3.34, SD = 1.01) with the lowest rated item (22) being a mean of 3.20. Table 4 presents the statistical outcomes for the CBT-E scale.

Table 4 Scale 3 CBT-E: Item Statistics

Item		Mean	SD
20	I believe existential themes are a vital component of any therapeutic approach	3.34	1.01
21	I would consider using a meaning-based approach such as existential therapy with my clients	3.61	0.92
22	I have actively sought to improve my knowledge and/or ability with meaning based approaches, such as the inclusion of existential themes	3.20	1.06
23	I intend to pursue the further integration of CBT techniques with existential themes in my own practice	3.27	0.94
	Average Mean	3.35	

4.2.6 Discussion of CBT-E

Despite these findings that a majority of respondents would consider using a meaning-based approach in their therapeutic practice, with just under half agreeing/strongly agreeing that existential themes would be a vital component of this, a similar dissonance arises to that found emerging from Questionnaire 2 (SET). Namely, that there is a considerable gap between respondents' expressed belief that it is important to address existential themes in therapy (item 20), and then actually intending to use them in therapy (item 23), with 44% who either agree or strongly agree, and 38% choosing to remain neutral (M = 3.27, SD = .94). As such, there is also a dissonance regarding the likelihood to follow through, which ultimately may impact not only the foundation of understanding and direction for individual therapeutic relationships, but

also the trajectory and outcomes of those relationships. It is true and widely accepted that therapists should take a back seat, so to speak, whilst clients should be the ones who lead sessions (Beck, 1991; Crane et al, 2013).

4.3. Comparative discussion of the results from the three scales

Table 5 shows the distribution from the highest to the lowest item ratings.

Table 5 Items ranked according to descending means

No	Item	Mean	SD
5	I have in the past guided therapy sessions away from 'big issues' because I was unsure of how to use CBT to deal with them (note: this is the reverse score)	4.09	0.81
6	I feel comfortable in freely adapting the CBT techniques learned during training	3.94	0.79
7	Overall, I am satisfied with the use of CBT with my clients	3.69	0.96
3	My training in CBT techniques covered a comprehensive base of potential client issues	3.67	0.97
21	I would consider using a meaning-based approach such as existential therapy with my clients	3.61	0.92
12	Do you have a philosophy of life that helps you manage stress and crises or make decisions?	3.46	1.12
20	I believe existential themes are a vital component of any therapeutic approach	3.34	1.01
23	I intend to pursue the further integration of CBT techniques with existential themes in my own practice	3.27	0.95
22	I have actively sought to improve my knowledge and/or ability with meaning-based approaches, such as the inclusion of existential themes	3.20	1.07
1	I find CBT techniques provide me with all the tools I need in my therapeutic work	2.97	1.14

13	Do you think about ideas such as eternity, truth, justice and goodness?	2.87	0.97
9	Do you ever reflect on your purpose in life?	2.81	0.93
4	I have found CBT to be effective in situations involving the discussing of 'big issues', e.g. the purpose of life, the existence of God, anxiety or identity.	2.76	1.06
11	Have you ever spent time reading, thinking about or discussing philosophy or your beliefs?	2.76	0.99
2	I would be comfortable using CBT techniques with my client regardless of the issues they present.	2.72	1.14
17	Have you ever thought about what is beyond the 'here and now' of your daily life?	2.65	0.97
18	Do you ever think about life's 'Big Questions'?	2.64	0.95
19	Have you ever reflected on the nature and reality of the universe?	2.55	0.96
10	Do you ever think about the human spirit or what happens to life after death?	2.54	0.98
15	Do you discuss or ask questions to probe deeply into the meaning of life?	2.46	1.01
14	Do you spend time in prayer, meditation or reflecting on the mysteries of life?	2.25	0.93
16	Do you ever think about a 'grand plan' or process that human beings are a part of?	2.16	1.08
	Average Mean	2.89	

When viewed as a group, it was found that the highest rated items were all contained within the CBT-E scale (mean = 3.35) and the CBT-S scale (mean = 3.28), whilst the lowest rated items were in the SET scale (mean = 2.65). This could be due to the different scales used. CBT-S and CBT-E use an agreement scale, whilst SET uses a frequency scale; the SET scale has six options with different scale descriptions. The 6th item, the neutral 'I don't know' option, in accordance with the SET scoring instructions, was excluded from the scoring.

Ultimately, these responses demonstrated a majority opinion from respondents who have used or indicated commitment to CBT, that they do, in fact, find it useful for their clients. However, there was also an indication that, for these respondents, existential therapies offer a useful adjunct to their practise of CBT. This is supportive of a study conducted by Ottens and Hanna (1998) where they found that, whilst cognitive and existential therapies are typically viewed as being so far apart that they are incompatible, they would entertain integrating the two to determine if such a merge is beneficial for their clients. By combining these treatments, existential therapy could help the therapist to better understand the clients' formation of core schemas, which are the basis for understanding beliefs and negative biases. This diagnosis, in turn, lends itself to cognitive behaviour treatment methodologies. Nevertheless, as the survey findings related to the disconnect between professed willingness towards integration and actual practice suggest, therapists must first commit to integration and do so consistently rather than disjointedly in order for it to be effective.

The survey findings also provided a clear demarcation as to what respondents would and would not do in their practices. The highest disagreement rating came from 70% of respondents (i.e. who disagree or strongly disagree) on item 5, who stated that they would *'have in the past guided therapy sessions away from 'big issues' because I was unsure of how to use CBT to deal with them*'. The respondents were also flexible in the sense that 54% said they would not use CBT in every circumstance (item 2) and, on item 1, 46% did not agree that CBT provided all the tools they needed (i.e. disagreed or strongly disagreed). This suggests that respondents were clear about when CBT or other therapies applied and when they did not. This follows Tolin's argument, who noted that some past studies have shown that CBT performed better than psychodynamic therapy for treating depressive disorders and anxiety, and therefore ought to be "a first-line psychosocial treatment of choice" (Tolin, 2010, p.710).

And yet, Butler et al.'s (2006) meta-analysis also found that CBT was moderately effective for treating marital distress, anger, and chronic pain. This is rooted in the fact that whilst such issues are traditionally treated with a step-by-step, managerial, CBT approach, they are fundamentally affective issues linked to existential phenomena. For instance, issues such as marital distress are potentially linked with a number of existential issues, including finding or creating meaning in one's life via pleasurable and fulfilling relationships. These issues appear to require a more flexible approach than that offered by strict adherence to traditional CBT, but depends on the therapist formulation as to what to do with the client. Thus, it is axiomatic and a burdensome, high stakes endeavour that the therapist must decide what treatment is most appropriate and when to use it. This, of course, must stem from an assessment of an individual's diagnosis, the severity of the diagnosis, and other factors such as ethnic, cultural, and religious factors that influence clients.

Regarding the findings of this research, some respondents were interested in pursuing a more holistic approach, whereas others were quite strict in their positions regarding pursuing CBT and only CBT. These are matters that are particularly explored by scholars such as Miranda *et al.* (2005), Gater *et al.* (2010), and Rathod *et al.* (2010). An integrative framework is essentially what Helmsley (1998) was advocating when he proposed that the therapist must fully understand the client's unique worldview and perspective in order to have a basis for measuring the degree of the delusion that a patient may have before any effective therapy could commence.

Questionnaire 3's (CBT-E) item 22 shows that 28% of respondents have not sought to improve their knowledge of meaning-based approaches, compared with 44% of those who had.

Deducing whether former respondents were already trained in existential techniques, were disinterested in learning more about the techniques, or had not as yet taken the time to pursue additional training yet was difficult from these responses. However, the results do suggest that twice as many respondents were interested in increasing their knowledge of existential or meaning-based therapies as those who had no interest in doing so. This, relating to the study's research question (to better understand CBT therapists' perspectives on incorporating an existential component within their CBT practice), is promising and indicative that therapists perception of the gulf between CBT and existential therapy is smaller than perhaps has been previously argued. Moreover, these results suggest that, as more therapists become more cognisant of existential therapy as a valid supplemental and augmentative approach, clients will have greater tools and mechanisms by which to address their various personal and interpersonal struggles.

Ultimately, the survey results responding to the research question regarding CBT therapist satisfaction with CBT suggest that these respondents are firm in their approval and utility of CBT techniques for treating their patients. They are also grounded in their own beliefs about 'life's big questions,' such as the human spirit and life after death. Overall, they do not feel the need to steer clear of matters of the spirit or philosophical issues that may not fit with their CBT methods. The findings indicate that whilst they will modify - or are open to modifying - their approaches to fit the circumstances, they will not introduce a treatment modality that is not appropriate, regardless of whether it is *au courant* or not.

4.4 Testing the hypothesis: Correlations between scales CBT-S, SET and CBT-E

Spearman's rho correlation was conducted due to the absence of normal distribution. The correlation included CBT-S items, the average CBT-S score, all the SET items, and all the CBT-E items. Due to the novel nature of the research and the original scales designed, a broader and exploratory analysis was carried out. The alpha was set at $p < .01$ in order to provide control for the multiple tests.

This analysis aimed to respond to one of this study's objectives; namely, to test the hypothesis that as existential thinking increases, satisfaction with CBT decreases. The correlation that was most imperative was between the CBT-S mean score and the SET mean score. The Spearman's rho revealed no relationship between the average CBT-S score and the average SET score ($rs = -.04$, $p = .47$, $n = 240$).

The highest correlations involved items 11 and 15 on the SET scale and each of the four items on the CBT–E scale (items 20 to 23). These items queried existential concerns and considerations. An analysis of this data revealed that the more satisfied respondents were with CBT, the less inclined they were to seek out existential therapy as another/ alternative approach. This may have something to do with existentialism itself, or it may just be a product of therapists not having an interest in any other approach as long as CBT meets theirs and their clients' needs, as expressed in items 1, 7, and 21. The following sections discuss these correlations and their implications in further detail.

4.4.1 Summary of correlations between SET, CBT-S and CBT-E scales items

The statistically significant correlations that emerged are as outlined in the following three tables:

Table 6 - Correlations between CBT-S items and CBT-E items

Table 7 - Correlations between CBT-S items and SET items

Table 8 – Correlations between CBT-E items and SET items

Table 6 Correlations between CBT-S items and CBT-E items (n = 236)

CBT-S Item	I find CBT techniques provide me with all the tools I need in my therapeutic work (Item 1)	My training in CBT techniques covered a comprehensive base of potential client issues (Item3)	I feel comfortable in freely adapting the CBT techniques learned during training (Item 6)	Overall, I am satisfied with the use of CBT with my clients (Item 7)
CBT-E Item				
I believe existential themes are a vital component of any therapeutic approach (Item 20)		rs (236) = -.162, p = 0.01		rs (236) = -.259, p < .01
I would consider using a meaning-based approach such as existential therapy with my clients (Item 21)	rs (236) = -.273, p < .01			rs (236) = -.298, p = <.01
I have actively sought to improve my knowledge and/or ability with			rs (236) = .160, p = .01	

meaning based approaches, such as the inclusion of existential themes (Item 22)			
I intend to pursue the further integration of CBT techniques with existential themes in my own practice (Item 23)	rs (236) = -.158, p = .01	rs (236) = .163, p = .01	rs (236) = -.203, p < .01

Table 7 Correlations between CBT-S items and SET items (n = 239)

CBT-S Item	I find CBT techniques provide me with all the tools I need in my therapeutic work (Item 1)	I would be comfortable using CBT techniques with my client regardless of the issues they present (Item 2)	I have in the past guided therapy sessions away from 'big issues' because I was unsure of how to use CBT to deal with them (Item5)	I feel comfortable in freely adapting the CBT techniques learned during training (Item 6)	Overall, I am satisfied with the use of CBT with my clients (Item 7)
SET Item					
Do you ever reflect on your purpose in life? (Item 9)					rs (239) = -.154, p = .01
Have you ever thought about the human spirit or what happens to life after death? (Item 10)	rs (239) = -.203, p < .01				rs (239) = -.154, p = .01
Have you ever spent time reading, thinking about or discussing philosophy or your beliefs? (Item 11)	rs (239) = -.159, p = 0.01				rs (239) = -.218, p < .01

Do you spend time in prayer, meditation or reflecting on the mysteries of life? (Item 14)				rs (239) = -.152, *p* = .02
Do you discuss or ask questions to probe deeply into the meaning of life? (Item 15)	rs (239) = -.181, *p* < .01			rs (239) = -.163, *p* = .01
Have you ever thought about what is beyond the 'here and now' of your daily life (Item 17)	rs (239) = 0.152, *p* = .02			
Have you ever reflected on the nature and reality of the universe (Item 19)	rs (239) = -.210, *p* < .01	rs (239) = -.200, *p* < .01	rs (239) = .172, *p* < .01	
Existential scale score	rs (239) = -.158, *p* = .01		.	

Table 8 Correlations between CBT-E items and SET items (n = 236)

CBT-E Item	I believe existential themes are a vital component of any therapeutic approach (Item 20)	I would consider using a meaning-based approach such as existential therapy with my clients (Item 21)	I have actively sought to improve my knowledge and/or ability with meaning based approaches, such as the inclusion of existential themes (Item 22)	I intend to pursue the further integration of CBT techniques with existential themes in my own practice (Item 23)
SET Item				
Do you ever reflect on your purpose in life? (Item 9)		rs (236) = .385, $p < .01$	rs (236) = .346, $p < .01$	rs (236) = .435, $p < .01$
Have you ever thought about the human spirit or what happens to life after death? Item 10)	rs (236) = .346, $p < .01$		rs (236) = .325, $p < .01$	
Have you ever spent time reading, thinking about or discussing philosophy or your beliefs? (Item 11)	rs (236) = .430, $p < .01$	rs (236) = .454, $p < .01$	rs (236) = .437, $p < .01$	rs (236) = .430, $p < .01$

Do you think about ideas such as eternity, truth, justice and goodness?(Item 13)		rs (236) = .225, $p < .01$	rs (236) = .228, $p < .01$	rs (236) = .359, $p < .01$
Do you spend time in prayer, meditation or reflecting on the mysteries of life?(Item 14)		rs (236) = .481, $p < .01$	rs (236) = .348, $p < .01$	
Do you discuss or ask questions to probe deeply into the meaning of life? (Item 15)	rs (236) = .537, $p < .01$		rs (236) = .498, $p < .01$	rs (236) = .538, $p < .01$
Have you ever thought about what is beyond the 'here and now' of your daily life? (Item 17)	rs (236) = .349, $p < .01$	rs (236) = .296, $p < .01$	rs (236) = .309, $p < .01$	rs (236) = .377, $p < .01$
Have you ever reflected on the nature and reality of the universe (Item 19)	rs (236) = .357, $p < .01$	rs (236) = .340, $p < .01$	rs (236) = .342, $p < .01$	rs (236) = .325, $p < .01$
Existential scale score	rs (236) = .510, $p < .01$		rs (236) = .420, $p < .01$	

Although they might have been correlated (and statistically significant), the correlation coefficient was very low in many of the cases. The highest negative correlations that emerge involve items 10, 11 and 15 on the SET scale. These items dealt with whether each therapist personally "*thought about what happens to life after death*" (item 10), "*spent time reading, thinking about or discussing philosophy or beliefs*" (item 11), or "*probe deeply into the meaning of life*" (item 15). When paired with the CBT-S scale item 1 (i.e. the extent to which they feel CBT provides all their needed tools for therapy) and scale, item 7 (i.e. the extent to which they are satisfied with the use of CBT), these comparisons demonstrated further dissonance. There were only two positive correlations between SET and CBT-S. One involved SET scale item 17 (i.e. thinking about what is beyond the here and now in daily life) and CBT-S item 1. The other involved SET item 15 (i.e. discussing and asking questions to probe the meaning of life) and CBT-S item 6 (i.e. the extent to which they feel free to adapt CBT techniques).

4.4.2 Discussion of correlations

The primary implication of these findings is that respondents who personally spend time reading about, thinking about, and discussing existential concepts are most open to introducing existential concepts into their practice and adapting CBT techniques as needed to suit the circumstances. Conversely, those who entertain such concepts infrequently are not as open to introducing such concepts into their practices. For example, as evidenced in Table 8, there were positive correlations showing that therapists who "*discuss or ask questions to probe deeply into the meaning of life*" (item 15) are more likely to believe existential themes are vital (item 20), improve their knowledge and/or ability with meaning-based approaches (item 22), and pursue further the integration of CBT techniques with existential themes (item 23). Accordingly, with more personal engagement of existential issues, there tends to follow more of a commitment to

integrate existential elements into CBT as a means of providing a more comprehensive therapeutic approach.

Interestingly, Table 10 highlights the type of dissonance previously mentioned concerning turning existential thinking into existential action in therapeutic practice. Wholly regarded, the scale correlations suggest that the willingness to incorporate existential themes into CBT is related with the practitioner's personal beliefs and practices regarding existential philosophies, as well as an openness to modifying CBT methods when appropriate. These patterns of association between the beliefs and values of the therapist, and the range of issues that existential therapy addresses, are arguably not incongruous because CBT expects the therapist to become directly involved as an active participant in the client's solution. These findings also suggest that respondents understand that the therapist needs to have a degree of comfort in discussing "*big issues,"* the meaning of life, and spirituality in order to be effective in addressing client issues of this type. In contrast, the dissonance exists in the noted ambivalence to bridge the gap between what respondents have deemed to be suitable to explore for themselves, as compared with that which they find to be acceptable to explore for and with their clients. Whether this dissonance is based on fear, anxiety of doing something wrong, lack of interest, or some combination of these, is still unclear.

4.5 Testing the hypothesis Summary: As 'existential thinking' increases, satisfaction with CBT decreases.

Despite the fact that a negative correlation between existential thinking and satisfaction with CBT was not supported by a measure of statistical significance here, a trend can nonetheless be observed. Those respondents who were seemingly already adjusted to and satisfied with CBT

were less inclined to look beyond that approach or concerned with existential issues due to the low negative correlations between some SET and CBT-S items.

Moreover, item 4 on the CBT–S scale (table 5) ('*I have found CBT to be effective in situations involving the discussing of 'big issues', e.g. the purpose of life, the existence of God, anxiety or identity*') was the 2nd lowest rated item on that scale. The highest mean rating on all 23 items was on item 5 (as shown in table 8) on the CBT–S scale ('*I have in the past guided therapy sessions away from "big issues" because I was unsure of how to use CBT to deal with them*').

From this, it can be deduced that respondents felt that CBT was not an optimum therapy for addressing 'big issues'. Similarly, some practitioners steered away from 'big issues' because they did not feel comfortable with CBT's appropriateness or their capabilities for addressing those issues, as will be further elicited in the analysis of their responses to the open-ended questions. This seemed to confirm the gap found in the literature relating to what CBT provides and what it lacks in terms of digging deep to address more 'big issues'.

Moving on, further support for the study's hypothesis can be found in Table 8. The five lowest rated items, with means ranging from 1.16 to 1.55, all dealt with topics such as a grand plan, reflecting on the mysteries of life, probing deeply into the meaning of life, or what happens to life after death. Since all of the respondents were CBT trained practitioners, it is reasonable to assume that they may have felt inadequate in addressing these issues purely using CBT. A corollary to that is that, with the 237 respondents' ratings on the CBT-E subscale (items 20 -23), as many as 63% indicate their intent to actively pursue existential training. Their ratings on these items ranged from 44% to 63% (agree or strongly agree), which confirmed their belief that existential themes were vital, and that they are actively seeking to improve their knowledge, skills

and abilities in existential therapies so that they could integrate these with CBT. This does not necessarily prove dissatisfaction with CBT as much as it indicates a conviction that existential therapies have potential to supplement their ability to serve their clients better and to compensate for some perceived limitations of traditional CBT. In essence, CBT and existentialism are potentially augmentative.

The following sections consider further analysis and implications according to therapists' characteristics.

4.6 Gender response differences

In order to establish whether there were any significant gender differences between responses across the three scales, independent sample t-tests were run. Table 9 presents the means and standard deviations that emerged.

Table 9 Mean (and standard deviations) scores for females and males respectively on the CBT-S, SET and CBT-E scales

	CBT-S average score	**SET** average score	**CBT-E** I believe existential themes are a vital component of any therapeutic	**CBT-E** I would consider using a meaning-based approach such as existential	**CBT-E** I have actively sought to improve my knowledge and/or ability with meaning based	**CBT-E** I intend to pursue the further integration of CBT techniques with existential

			approach (Item 20)	therapy with my clients (Item 21)	approaches such, as the inclusion of existential themes (Item 22)	themes in my own practice (Item 23)
Female (n = 160)	3.38 (0.57)	1.97 (0.98)	3.36 (0.98)	3.58 (0.95)	3.15 (1.09)	3.26 (0.86)
Male (n = 77)	3.43 (0.67)	2.16 (0.87)	3.30 (1.04)	3.68 (0.85)	3.31 (1.01)	3.28 (1.09)
Combined (n = 237)	3.40 (0.60)	2.04 (0.93)	3.34 (1.01)	3.61 (0.92)	3.20 (1.06)	3.27 (0.94)

No significant difference was found between males and females for the CBT-S average score [t (1,241) = -.56, p = .57. partial η^2 = .08], the existential scale percentage [t (1,238) = -1.43, p = .15. partial η^2 = 2.57], or any of the CBT-E scale items (all $p > .05$).

The results shown in Table 9 indicate that choosing to integrate existential elements into one's practice is not as simple as a differential matter of being a male or female therapist. On the contrary, and in line with previous research, such decisions actually appear to be based on internal personal value systems, orientation, and openness. This can be influenced by one's gender and even his or her identity politics, but these are mere singular factors and not the only ones that determine whether a practitioner employs an existential approach.

4.7 Occupation response differences

Further t-tests were conducted to determine if there were any significant differences in terms of how those from different settings or occupations answered the questionnaires. Means and standard deviations can be found in tables 10 and 11.

Table 10 Mean and standard deviations for the CBT-S, SET and CBT-E items, by different occupations

	CBT-S average score	**SET** average score	**CBT-E** I believe existential themes are a vital component of any therapeutic approach (Item 20)	**CBT-E** I would consider using a meaning-based approach such as existential therapy with my clients (Item 21)	**CBT-E** I have actively sought to improve my knowledge and/or ability with meaning based approaches, such as the inclusion of existential themes (Item 22)	**CBT-E** I intend to pursue the further integration of CBT techniques with existential themes in my own practice (Item 23)
Clinical Psychologist (n = 36)	3.45 (.70)	1.92 (.84)	3.09 (1.02)	3.62 (.85)	3.32 (.97)	3.24 (.85)
Counselling Psychologist	3.23 (.65)	2.22 (1.0)	3.5 (1.31)	3.92 (1.16)	3.42 (1.37)	3.42 (1.31)

(n = 12)						
CBT trained therapist (n = 178)	3.40 (.61)	1.97 (.92)	3.31 (.98)	3.55 (.92)	3.05 (1.05)	3.18 (.95)
Counsellor (n = 34)	3.23 (.51)	2.25 (.91)	3.65 (.95)	3.85 (.74)	3.53 (1.1)	3.59 (.98)
Other (n = 38)	3.40 (.59)	2.13 (.92)	3.43 (1.11)	3.73 (.99)	3.62 (.95)	3.51 (.95)

No significant differences were noted. Overall, however, counsellors were in most agreement with CBT-E scale items (34 in total), which involved the belief that existential themes are a vital component of any therapeutic approach (item 20), and a willingness for further integration of CBT techniques with existential themes (item 23). The implication here would be that practitioners occupying roles with more prescribed parameters, such as clinical psychologists and CBT trained therapists, would be less likely to integrate these. Counsellors, because they tend to be more involved with the meaning-making aspect of therapy rather than the clinical work and treatment associated with symptom management, also tend to be more liberated when addressing existential themes (Wong, 2012). Interestingly, or ironically, one could argue that the opposite would occur. Classically trained practitioners tend to have the advanced philosophical or psychological tools associated with classical understanding of human behaviour and affect, compared to counsellors who tend to focus their studies and professional expertise on client issues rather than on a greater and higher understanding of individual experiences. Thus, they exist both at the individual and collective levels with respect to clients (Christopher, Candilis, Rich & Lidz, 2011; Wong, 2012).

The potential impact of different work settings was also examined, as illustrated in table 11. The only significant differences found were between those working in secondary care and those working in other settings for the CBT-S scale [t (1,241) = -1.99, p = .04, partial η^2 = .09], and between those working in private practice and those in other settings for the CBT-S scale [t (1,241) = -2.23, p = .02, partial η^2 = .08]. There were no other significant differences in terms of how those in different settings or occupations responded to the scale items because all results were greater than the .01 level of significance, which is a commonly accepted threshold of significance to which social science researchers have generally agreed.

Table 11 Mean and standard deviations for the CBT-S, SET and CBT-E items, by different work settings

	CBT-S average score	**SET** average score	**CBT-E** I believe existential themes are a vital component of any therapeutic approach (Item 20)	**CBT-E** I would consider using a meaning-based approach such as existential therapy with my clients (Item 21)	**CBT-E** I have actively sought to improve my knowledge and/or ability with meaning based approaches, such as the inclusion of existential themes (Item 22)	**CBT-E** I intend to pursue the further integration of CBT techniques with existential themes in my own practice (Item 23)
Primary care (n = 84)	3.35 (.61)	1.98 (.92)	3.27 (1.02)	3.55 (.94)	3.12 (1.09)	3.27 (1.0)
Secondary care (n = 55)	3.54 (.66)	1.93 (.99)	3.08 (1.01)	3.53 (.89)	3.28 (1.04)	3.17 (1.04)
IAPT (n = 82)	3.31 (.63)	1.92 (.90)	3.16 (1.06)	3.60 (.99)	2.98 (1.08)	3.19 (.96)
Private practice (n = 68)	3.53 (.61)	2.01 (.99)	3.32 (1.04)	3.57 (.88)	3.16 (1.15)	3.13 (1.02)

Voluntary (n = 13)	3.27 (.43)	2.06 (1.11)	3.83 (1.03)	4.08 (.79)	3.92 (.90)	3.67 (.98)
Commercial (n = 5)	3.28 (.39)	1.98 (1.49)	2.80 (1.64)	3 (1.58)	3.20 (1.48)	2.80 (1.30)
Education (n = 17)	3.40 (.75)	2.26 (.85)	3.41 (1.06)	3.71 (.92)	3.29 (1.16)	3.25 (1.06)
Other (n = 29)	3.44 (.66)	2.09 (.91)	3.34 (1.04)	3.38 (1.11)	3.41 (1.01)	3.31 (1.03)

From the data, it is clear that there is much common ground as to how practitioners in various work settings view relationships between CBT practices and existential concepts. There is also consensus among all workgroups regarding the belief that existential themes are a component of any therapeutic approach. This is supported by the fact that the SD's range from 1.01 to 1.06, with the sole exception of the small group of five commercial workers who had an SD of 1.64.

4.8 Chapter summary

This chapter has provided key data and SPSS analysis for the first three questionnaires for the online CBT Satisfaction and Existential Thinking Survey. Whilst the survey results revealed no significant relationship between greater existential therapy exposure and CBT satisfaction, the data did suggest that the matter is more complicated and nuanced than originally conceived. Even though no strong correlations were present, respondents were nonetheless vocal about their beliefs concerning the potential intersection between CBT and existential therapy, including the need for therapists to bridge the division between approaches. This chapter highlights that this part of the research has identified three main points. Firstly, that there is general satisfaction with CBT, second, that there is interest in existential issues and thirdly, that some CBT therapists are open to further training in existential therapy to meet clients' needs for better therapeutic outcomes, to encourage clients to explore their own beliefs and values, and to lay emphasis on meaning and finding meaning, thus enhancing clients' understanding of the complexity of life and living. These understandings emerge in greater detail in the IPA analysis, as well as in the subsequent chapter, which presents the responses to the open-ended, free response questions that were also part of the online survey, and offers a critical reflection on these.

Chapter 5 – Open-ended questions Response Results and Integrated Discussion ('mixed strand')

CBT Satisfaction and Existential Thinking Survey: Open-ended response results and integrated discussion

5.1 Introduction

This chapter presents the results obtained by qualitatively analysing the participants' free text answers to the four open-ended questions included in the CBT and Existential Thinking Survey, and their main implications. This is followed by a discussion integrating the findings drawn from both parts of the online survey. The chapter concludes by discussing the overall limitations of the online study, and in particular of the free text responses' section.

Table 12 The survey open-ended questions and corresponding topic/theme

Open-ended question	**Topic/theme**
5.2 - Outline your current awareness of meaning-based approaches/existential themes, including any training you have received or personal research you have undertaken.	5.2.1 - Awareness and understanding of 'meaning-based approaches/existential themes' 5.2.2 - Types of training 5.2.3 - Relevant research undertaken by respondents 5.2.4 - Other topics
5.3 - If you have integrated existential themes into your CBT sessions in the past, outline your motives for doing so. If you	5.3.1 - Reasons for integrating existential themes into CBT sessions

have not, please outline your reasons for not doing so.	5.3.2 - Reasons for *not* integrating existential themes into CBT sessions 5.3.3 Reasons for integrating existential themes into CBT sessions only under certain circumstances
5.4 - If you would consider integrating existential themes into your CBT sessions in future, what would you hope to achieve by doing so?	5.4.1 - Anticipated outcomes of integrating existential themes into CBT sessions 5.4.2 - Other comments on integrating existential themes into CBT sessions
5.5 - If you have any further comments, please provide them below?	

The following sections highlight and summarize the results for each of these questions, integrating anonymised quoted responses where appropriate.

5.2 Outline your current awareness of meaning-based approaches/existential themes, including any training you have received or personal research you have undertaken

Respondents referred to a number of elements of their experiences and understanding when answering this question. Yet, most did not cover every aspect mentioned in the question (awareness, training and research). Some detailed the training they had received, although in many instances it was unclear whether this included any tuition on existential themes or therapy. Others described their academic, career-related and personal research on the subject, whilst others still listed those topics that they understood as forming part of 'meaning-based approaches/ existential themes'.

The following sub-sections and tables summarise the themes raised by respondents to this open-ended question. The tables have been separated into the core areas addressed; namely, respondents' awareness and understanding of 'meaning-based approaches/ existential themes', respondents' training and research background, and other issues raised.

In total, 124 respondents answered this question. The 'n's quoted in the tables denote the number of participants mentioning each topic or theme in their responses to this question. The percentages quoted are also based on the total number of respondents and rounded to the nearest whole number. These do not total 100% because many respondents did not fully explore each one of the questions' issues. For example, some mentioned only the type of training they had received and did not directly comment on their understanding of meaning-based and existential approaches.

5.2.1 Awareness and understanding of 'meaning-based approaches/existential themes'

Respondents mentioned the range of topics shown in Table 13 as being part of what they consider to be meaning-based and existential approaches.

Table 13 Main themes reflecting respondents' understanding of meaning-based and existential approaches

Topic/theme	N	%
Mindfulness	12	10
Meaning/finding meaning	11	9

Spiritual interests	10	8
Death and dying	6	5
Self	3	2
Compassion	1	1
Forgiveness	1	1
Relationships, reciprocal roles, etc.	1	1
Values	1	1

Mindfulness was the most frequently mentioned topic, closely followed by discussions around the search for meaning, and around spiritual interests. There were, at times, both implicit and explicit connections drawn between mindfulness and not only a client's need to be aware of his or her emotional and psychosocial surroundings and needs, but also a need for the respondents – the therapists – to explore such a mentality in a manner that could be supported by others, namely the scholarly community. When respondents felt they were able to adopt a mindfulness mentality, on their own terms, they could better assist their clients by travelling with them while they determined how to fully understand the various issues affecting them. Though not explicitly stated, this possibility is significant for a number of reasons.

Per the gaps noted from the literature review, such a shift in awareness conceivably allowed respondents that space to become more culturally open-minded in terms of addressing the needs of diverse clientele. Moreover, by focusing on mindfulness, the respondents found a gateway to discuss issues (e.g., distress and anticipated grief) in

terms of what clients thought or believed, and to do so in such a manner that was underscored by their own understanding, ideas, and experiences of such issues. At least one respondent was able to move to a place in which he and his client were collaborative agents working for the betterment of the client to find his own life meaning, and in a way that also had positive and illuminating externalities for the therapist. Comments suggesting these results included the following: *"Use of mindfulness and acceptance in CBT, finding meaning in the midst of distress."*

For at least the respondent responsible for the above comment, the introduction and/or presence of mindfulness, as well as acceptance, acted as a conduit for a client to find meaning in spite of the fact that the said client may otherwise be experiencing distress. In such a manner, it could be argued that mindfulness was both a channel to, as well as a manifestation of, psychological and, more specifically, emotional relief.

Though mindfulness was a prevailing concept, it was not always one that was explicitly stated or recognised. Rather, it was used interchangeably with the need for study participants to work with their clients in order to help them create or find meaning in their lives, and may be determinant for the clients' therapeutic path. The following quote shows how finding meaning was perceived as a necessity that affected every aspect of one's life: *"I believe we need to make some sort of meaning out of everything and one problem we have is to create a meaning for our life."* Mindfulness can play into an actual human need to create a reason for living; perhaps one that is customised to each individual, and can only be comprehended following a process of getting in touch with oneself.

"Initially I did not think CBT would include this, but with the growth of mindfulness based CBT I have been pleasantly surprised to find that my original interests are now being integrated within mainstream CBT. I have always been interested in the borderline between spirituality and psychosis - having attended some of the conferences held at Southampton on that subject, I have found my openness to the idea of spirit, soul and a possible afterlife has helped me form a much better therapeutic relationship with some clients than some of my colleagues who do not have this interest."

For the respondent offering the answer above, there was a profound connection between mindfulness and marrying CBT to more existential ideas and concerns, namely, spirituality and, specifically in the intersection between spirituality and psychosis. In this context, mindfulness seemed to be regarded more as a process than a static idea or a command to act in a certain way. The respondent's words harken to the allusion of mindfulness as a conduit or channel towards better individual understanding that can also lead to relief or peace. As described, such inclusion of mindfulness in his cognitive-behavioural therapeutic work seemed to benefit the respondent's ability to establish a more satisfactory therapeutic alliance with some clients, and to have the support of his peers.

A reasonable extension of mindfulness, which can be thought of as a broad concept or idea, is transitive in that it demands that therapists actively and continuously encourage clients to talk about the issues that few, if any, truly want to discuss – issues such as death and dying. In the course of this research, these topics were mentioned by six respondents as forming part of their understanding of meaning-based and existential approaches. Moving on from mindfulness, which is arguably a precursor to being able to both

intellectually and emotionally process more harrowing concerns such as death and dying, the six respondents revealed that both topics are also linked with two of the greatest affective issues that clients bring to therapy – anxiety and depression (Kessler et al., 2009). The two phenomena are described as if two sides of the same coin, especially when clients and therapists take a step back to think of not only their own mortality, but also that of loved ones. This phenomenon was highlighted by one respondent, in particular, who also noted that many of his clients indicated that they saw or heard dead people or felt their presences:

> *"Concepts of death and the afterlife [are] likely to arise in anxiety and depression. Death is a common theme in therapy - bereavement/health issues. Many clients have 'unusual' (such as seeing/hearing dead people or feeling presences) experiences, which impact on their mental health."*

This is something that can be explored in the context of Health Anxiety, as noted by one respondent who stated the following*: "I like to try to work with what the client brings - core beliefs and assumptions tend to have a common pattern throughout areas of someone's life. Beliefs about death may be central in Health Anxiety."* Moreover, in together accepting such realities, another respondent noted that he and clients could create relationship dynamics, as favoured by Yalom, in which he is both a guide and fellow sojourner with clients: *"I have an interest in Yalom's work on death, anxiety and anticipatory grief as well as concepts such as transiency and ripping, and find them useful to consider with clients."*

Three people mentioned the concept of the 'self' as forming a constituent part of meaning-based and existential approaches, as is illustrated by the following: *"ACT's 'self as context' or 'observer self' has been pretty significant both personally and for many of my clients."*

Some respondents stated that the incorporation of these concepts into their therapy was part of a natural or organic process rather than an explicit attempt at introducing existential themes. It was also commonly considered important to include these topics only where the presenting problem(s) or the client/patient demanded such discussion. That is, a focus on the "self" was best brought up as happenstance rather than a planned strategy. This is conveyed in the following response: *"I do not give it a lot of thought, if patients tend to get caught up with it (although I have not had any experience of this happening with any of the patients I have seen thus far), I tend to use an element of mindfulness and bring in compassion into the patients' awareness."* In this case, the respondent noted that if a client presents with issues that could benefit from such an approach, he would use it, but he essentially has neither outright intent to use it nor has needed to use it in the past.

The rationale behind this was that exploration of the self must be driven by the client even if aided or guided by the therapist. There must be a client-driven catalytic event, thought, or belief that leads to transition; this is something that is highlighted by the respondents' various answers. One respondent asserted many clients do not present with actual symptoms as that which ails them in that regard, but rather with existential issues that touch different aspects of their lives in a manner that extends beyond simple symptomology. As he perceived himself, he did not shy away from exploring these, as

conveyed in the following response: *"I regard myself as a therapist that is willing to work with 'meaning', as most clients present not only with 'symptoms' but existential problems and want to know what meaning there is behind their problems."* Interestingly, another respondent noted his lack of real intent to incorporate mindfulness, at least in the same manner as the previously described respondent. In the end, both indicate that it can be beneficial, but the origins of the intent to use it differ. In one case, the therapist is already cognisant and likely to use mindfulness as a tool based on an understanding of a client's needs in conjunction with his own beliefs and trusted techniques. In the other case, the therapist waits for a cue from clients before incorporating mindfulness without considering at the outset that the client would be interested in or has existential issues.

However, there was also a sense within some of the comments that respondents felt somewhat frustrated with the lack of freedom to explore existential themes. Consequently, there was a bit of tug-of-war in which respondents had the tools and desire to explore existential themes, but felt as if they lacked the peer support to be liberated in doing so. This was particularly the case where some felt tied into employing only 'traditional' CBT techniques (Rhodes & Jakes, 2009). Several mentioned that the IAPT training they had undergone seemed very closed to the notion of existential themes in CBT, thereby restricting their use (Rhodes & Jakes, 2009), and that more objective-leaning CBT techniques were favoured instead of those specifically developed for their flexibility so as to organically assist the most clients in the most customised manner (Joseph, 2016). As one participant remarked:

> *"I am deeply reflective and interested in the spiritual side of life which at times has been a source of difficulty within the CBT world, particularly with my tutors.*

For example, I struggled with my IAPT training and was criticised for being 'too counselly'. […] I am using third wave treatment models within my daily practice but having to cover this up within supervision as it does not fit these restrictive IAPT protocols; however, if the clients benefit and I am working according to the BABCP code of conduct with the client's wellbeing and recovery at the forefront of my practice, I will continue to do this."

Conversely, another respondent welcomed the acceptance within their clinical setting of a more spiritual approach within therapy, when this was deemed appropriate: *"I feel that our Trust are developing themes of spirituality within practice, and I believe that this is a good thing."*

5.2.2 Types of training

In a small number of instances, although this survey question asked respondents to detail any training they had received in meaning-based and/or existential approaches, it was not always clear whether the training they stated had actually been a source of knowledge about this particular area. Table 14 presents the summary of their responses.

Table 14 Main themes reflecting respondents' types of training

Topic / theme	**N**	**%**
CBT	16	13
Existential Therapy / existential topics	12	10
Acceptance and Commitment Therapy	10	8
Philosophy	6	5

Integrative counselling	5	4
Theological / religious	4	3
Humanistic counselling	3	2
Irvin Yalom - interpersonal group therapy	3	2
Psychoanalysis	2	2
Psychotherapy	2	2
Cognitive Analytic Therapy (CAT)	1	1
Compassion Focused Therapy	1	1
Dissociative disorders	1	1
EMDR	1	1
Mental health nurse / practitioner	1	1
Mindfulness Teacher Training	1	1
NLP	1	1
Phenomenology	1	1
Reiki Healing	1	1
Solution-focused approach	1	1
Transpersonal psychotherapy	1	1

Whilst it was not clear whether the training that was alluded to in table 16 had actually been received, the types of training that the 124 respondents had received and that were most often mentioned were: CBT (16), Existential Therapy (12), and Acceptance and

Commitment Therapy (10). Understandably, given the topic of the survey, CBT training was the most frequently cited type, followed by specific training in existential therapy/approaches, and then the guidance received as part of Acceptance and Commitment Therapy training. The breakdown of the training for these therapy types is, in fact, consistent with that discussed in the literature, especially concerning that which the NHS promotes (Cooper, 2017). Though the NHS promotes CBT, there has been more room for the use of Existential Therapy and Acceptance and Commitment Therapy (ACT) in recent years, especially since ACT is often considered, in many ways, to be an offshoot of CBT (Bass et al., 2014). The following are illustrative quotes:

> *"I have a pretty good awareness of meaning-based approaches due to previous training and education; this is across the different therapies but particularly CBT and Existential Therapy - asking about meanings is central to either approach in my opinion."*
>
> *"I have trained as an Integrative Counsellor, which included a module on existential working. I have an existentialist philosophy and enquiring mind, which influences all I do."*

> *"I have investigated, read extensively, been trained and receive supervision in Acceptance and Commitment Therapy. It handles existential questions very effectively. It increasingly dominates my clinical practice."*

Some respondents had received more general (i.e., less therapy-specific) training that they also considered relevant to the use of existential approaches. For example, six people said they had a background in and/or had received training in philosophy, whilst four had

undergone training in theology or religious studies. It is important to distinguish between traditional conceptualisations of philosophy (Dryden & Neenan, 1999) and therapy herein as the two can often be improperly separated, especially with respect to the standard use of CBT techniques. Therapy, even within the field, tends to be recognised as a catch-all phrase lacking specificity and direction (Turpin, Richards, Hope & Duffy, 2008). This can be beneficial in terms of flexibility. However, when assessing the possibility that CBT in its current state is actually deficient and lacks a deeper approach, such vagueness of use may pose some difficulties. Respondents pointed towards a marriage of philosophy and therapy (Steffen & Hanley, 2014). That is, they seemed to be discussing philosophy *as* therapy, an approach which might stem from informal modes of learning and personal experiences rather than professional training. This would be optimal since such training could lead to an overall pedagogical shift within psychotherapy (Cooper, 2017). Some of the responses that highlighted such a practical or practiced belief in philosophy *as* therapy included the following:

> *"I completed my first degree in Christian studies, which included philosophical and theological modules."*

> *"I am a practising Catholic and a priest and a Jesuit, and I have degrees in philosophy and theology."*

> *"I have a BA degree in philosophy and have also studied Catholic theology for two years; I am comfortable with talking about any existential themes if it comes up in any of my sessions."*

As these remarks illustrate, there is a personal motivation or interest in religiosity, faith, and theology that was often associated with the use of philosophy as therapy. With perhaps the exception of the priest quoted herein, there are no explicit indications that the respondents are faithful people, marginally or deeply so. Rather, the answers merely show that their academic interests include theology and philosophy Nevertheless, by having been mentioned, their personal philosophical-theological leanings can be reasonably argued to have allowed them to reach out to clients in a manner that is flexible (Moja-Strasser, 1996) and consistent with meaning-making, personal truth creation (both of which are pillars of an existential approach), and to integrating methods that have been learned both in formal training modes and informally (Dryden, 2009).

Eleven other types of training were mentioned by respondents, each illustrating the range of backgrounds that survey respondents have come from, and the potential range of training that was regarded as incorporating existential themes.

5.2.3 Relevant research undertaken by respondents

As was the case with the training respondents had undertaken, those who had conducted personal, career-based or academic research relevant to existential themes cited a range of topics on which their research was based. These are presented in table 15.

Table 15 Main themes reflecting relevant research undertaken by respondents

Topic / theme	**n**	**%**
Existential themes / therapy	10	8
Yalom	10	8
Human creativity	2	2
Logotherapy	2	2
Forgiveness in therapy	1	1
Holistic approaches	1	1
Parapsychology	1	1
Phenomenology	1	1
Philosophy	1	1
Transcendent experiences	1	1
Transpersonal psychology	1	1

It was found that of the 31 respondents who had actually conducted career-based or academic research, they primarily did so concerning existential themes, in general (N = 10, 8%), and Yalom therapy techniques, in particular (N = 10, 8%), as indicated below:

> *"I have attended a brief (ten week) evening course in existential therapy. I often discuss existential themes with my clients; I have published on the integration of CBT with aspects of existentialism."*

"I have been interested in existential philosophy since secondary school and followed my interest during my university study (I completed Masters in Psychology in Poland where 'history of philosophy' was part of a curriculum). During my counselling studies I was interested in existential approach and I [wrote up] my BABCP accreditation from a stance of an existential practitioner."

"I've read Yalom's Group Analytic tome, and his pop psychology books of his case studies; likewise other existential therapy authors. I've undergone three years individual therapy which, though psychodynamic in theoretical orientation, dealt essentially with existential themes."

"I have an interest in Yalom's work on death anxiety and anticipatory grief, as well as concepts such as transiency and ripping, and find them useful to consider with clients."

In each response, there is a link to research interests based on an integrative, fluid, or flexible approach that seeks to move beyond simple evaluations of clients' issues to storytelling as a framework of identifying and understanding clients' issues in order to create actionable plans for healing – all of which are foundational to an existential approach and relatedly, staples of Yalom's approach, in particular (May & Yalom, 1989; Yalom, 1980).

5.2.4 Other topics

Table 16 presents a summary of other topics raised in response to this question.

Table 16 Other topics raised by respondents

Topic / theme	n	%
Not received any relevant training	22	18
Little or no awareness or understanding of these issues	18	15
Dissatisfaction with CBT	10	8
Existential therapy of little or limited use	6	5
Concerns that existential therapy will not be accepted into 'mainstream' therapy	4	3
Interested in exploring existential therapy further	4	3
Third wave CBT incorporates more existential themes	4	3
Other*	3	2
Compassionate Mind Therapy helps to meet existential needs with clients	2	2
Not undertaken any relevant research	2	2
Philosophical considerations (including existential) often arise in other therapies rather than needing to be an approach in its own right	1	1
Preference for 'traditional' CBT	1	1
Schema focused model of CT more compatible with addressing existential issues	1	1

*Of the three comments coded as 'other', two queried the use of the terminology 'meaning-based' in the question and the other stated that Wolpe (1986) had written about integrating existential approaches with behaviour therapy 32 years ago.

A predominant theme across these comments was that no training had been received on existential themes or approaches (22 people whose responses are included in table 18 stated this). Some of those who had received no training in this area indicated that this was something they would like to explore. Conversely, two respondents expressed the view that such training was not necessary, and that their existing approach was adequate to meet their clients' needs, thus suggesting how both formal and informal modes of communication and education can lead to existential proficiency (Dryden, 2009):

> *"I have limited awareness of meaning-based approaches/existential themes, and no training or personal research in this area. I would therefore not use this approach without training and further knowledge and awareness."*

> *"Limited current knowledge confined to personal reading and brief introduction re older adults during training - if my setting and client presentation indicated, I would actively develop and integrate more awareness and am interested personally, but finding time to keep up to date across so many paradigms is often a bit of a struggle."*

> *"Minimal. I don't really think there is any function in such approaches within CBT."*

Eighteen respondents mentioned that they had very little awareness or understanding of the issues around existential approaches, whilst six people explained that they felt such an approach had only limited use in therapy. Going beyond that, however, some respondents appeared to outright denigrate existential approaches by characterising them as "nonsense," primarily due to their focus on subjectivity rather than objectivity, at least in terms of metrics from which to gauge client progress. From the answers provided below, it is difficult to discern the origins of such sentiments, especially from the last respondent, but they clearly exist and seem to focus on this objective versus subjective binary that is, in many ways, perpetuated by the NHS (Rhodes & Jakes, 2009). One possible outcome with exclusively using one approach over any others – in this case CBT to the exclusion of anything else – is that there can be a lack of genuine therapist-client collaboration.

> *"I found my existential training interesting and stimulating but as a therapy approach, for example regarding BPD and extreme psychosis (Laing notwithstanding), I find it of little use. I find CBT offers more readily comprehensible and useful ways of conceptualising difficulties such as depression and anxiety."*

In contrast, however, other respondents simply noted their lack of existential training, free of pejorative judgement of existentialism, whilst at least one respondent noted his lack of training and contempt for the alternative to CBT, as conveyed by the following responses:

> *"I have little or no knowledge of existential frameworks."*
>
> *"I have no knowledge of existential therapy except reading Man's Search for Meaning."*

"I don't think that there is any empirical evidence that the 'existential approach' or any other similar nonsense has any proved effectiveness. Apart from the fact that 'any intervention is better than no intervention'."

Ten respondents replied to the question by describing areas of dissatisfaction with CBT. Many of them explained that they had addressed this by incorporating an existential approach into their therapeutic approach where appropriate. Amongst those who found that CBT has limitations, there was great praise for its ability to work alongside an existential approach, thus demonstrating, in their assessments, existentialism's flexibility as well as the fact that both CBT and existential approaches can be integrated in client-centered ways. Furthermore, respondents noted how there are practical manners in which to customise an integrative therapy approach for clients, especially when dealing with the unavoidable existential issues of life, e.g. death and dying, that can hinder individuals' abilities to interact in healthy and productive manners with others as expressed in the following comments (May & Yalom, 1989):

"I became dissatisfied with traditional CBT. I have investigated, read extensively, been trained and receive supervision in Acceptance and Commitment Therapy. It handles existential questions very effectively. It increasingly dominates my clinical practice."

The above respondent stated that, over time, he became dissatisfied with traditional CBT offers as he perceived. In this case, the respondent sought further training in alternative therapy approaches and found existential-like approaches such as ACT so useful that these became increasingly and critically more important in his clinical practice. As made explicit in the following comment, the reason for adopting these alternative approaches

seems to be related not only to their dissatisfaction with CBT but also to the will of better addressing clients' issues and handling so-called big life questions.

> *"I feel that CBT isn't always enough or just not potent enough. Many clients will return with the same issues; symptom alleviation is just that - it's not helping people to face the big questions that may help them to accept the human condition. In particular, I have found death anxiety to be a significant part of many clients' presentations - very different to health anxiety covered on the CBT course - but probably more of an issue with day to day people presenting to primary care."*

Here, the respondent points out that their experience has been that CBT fails to be strong enough to sufficiently assist his clients. The proof of this stems from the fact that, as he points out, many return to him to address the same issues. CBT, therefore, serves as a temporary, insufficient solution in such cases. Consequently, clients may temporarily alleviate symptoms, but not truly address the root causes of their issues, something which, according to him, can be achieved with an approach in which clients tackle life's big questions and existential issues.

Providing similar sentiments regarding CBT's effectiveness, the respondent who provided the comments below explains the situations he has faced as those in which CBT has not met all of the necessary criteria to be truly effective for some clients. Then again, he does note that this could be due to the fact that he has only used CBT in his practice for a relatively short period of two years, which included his training year. That is, he seems to appreciate the fact that his being a novice to CBT could still be manifesting itself as a hindrance to optimally assisting his clients with the approach.

"I sometimes find that CBT does not meet all the requirements of my clients, especially when working with adverse life events and circumstances, but as I have only been using CBT formally for two years, including the training year, I am uncertain as to whether this is due to my own inexperience and lack of skill, or whether CBT really is a case of 'horses for courses'.

Four respondents welcomed the use of existential themes and approaches, but raised concerns about them being adopted into the 'mainstream'. Indeed, literature has shown a lack of NHS-sanctioned treatment options that objectively aid individuals in the long-run. Long-term results have been shown to demand holistic and integrative skillsets based on understanding narrative and personal history – two pillars of existentialism – rather than just employing medicalised, restrictive, "*reductionist, dualistic and mechanical"* steps that tend to be devoid of the individualism and customisation required to truly learn to live with one's issues, anxieties, and fears in a harmonious rather than combative manner (Reis, 2014; Deurzen, 2002):

"I have had no formal training in existential therapy - I think this area seems under-developed in terms of training opportunities. I think there is no mention made of existential therapy in NICE guidelines, unless it's covered by the generic name of "counselling", so I doubt if this form of therapy is going to be picked up by IAPT. I suspect that existential therapy is not going to be strong in terms of building an evidence-base, in which case I doubt if the NHS, Department of Health etc., will show much commitment to adopting it as a form of therapy."

> *"The medical model can tend to be reductionist, dualistic and mechanical in nature; it restricts more than it can allow to be. Many of the underpinnings for the ways in which therapies are designed and delivered appear to have a 'blind spot' in relation to the bigger issues that our clients/patients may wish to make sense of, explore or attribute meaning to. This approach, across the services and systems that exist, may need redefining to include more inclusive and less diagnostically led interventions."*

Whereas the first respondent's comments directly point toward a deficit in the currently approved training opportunities in terms of existential approaches, the second respondent's comments are more indirect and suggest that the medical model, which is the mainstream approach, is too focused on the clinical aspects of clients' psychiatric diagnoses and consequent mental health and well-being, thereby failing to adequately take into account the "*bigger*" life questions and issues that tend to reverberate throughout clients' lives. Thus, there is a demand for more nuanced and focused attention upon these more transversal issues.

The specific approach adopted within the framework of CBT was also discussed by some respondents here, three of whom asserted that existential themes fit better with 'third wave' CBT (Chadwick, 2006) and with specific approaches such as the 'schema focused model' of cognitive therapy, or 'compassionate mind therapy'. What is perhaps most interesting about the provided respondents' answers is their varied expressions of how, over time, specifically during subsequent waves, CBT and existentialism started to be somehow integrated, both becoming more accessible, useful, and, alongside each other, part of some more mainstream therapeutic approaches. This was noted in the first two

responses provided below. The last two responses focus on how such approaches have evolved over the years, but specifically refer to the positive impact of schema-centric models that involve more existential narratives.

> *"I find that the 'third wave' of CBT approaches, such as mindfulness and Acceptance and Commitment Therapy, incorporate meaning-based themes into my CBT practice."*

> *"I originally trained as a yoga teacher 40 years ago, therefore existentialism has formed a fundamental part of my interest and knowledge. Initially I did not think CBT would include this, but with the growth of mindfulness based CBT I have been pleasantly surprised to find that my original interests are now being integrated within mainstream CBT."*

> *"Compassionate Mind Therapy's approach of 'we all just find ourselves here', 'this is one version of me', has also lead some clients to gain a different perspective on their existence, and this has had significance for their recovery."*

> *"As I am very interested in the Schema Focused model of Cognitive Therapy, I often find this model more compatible with conceptualising existential issues and including them in treatment plans."*

5.3 If you have integrated existential themes into your CBT sessions in the past, outline your motives for doing so. If you have not, please outline your reasons for not doing so.

Responses to this open-ended question tended to fall into three categories: the reasons for integrating existential themes into CBT sessions, the reasons for not integrating existential themes into CBT sessions, and responses indicating that existential themes were integrated only under certain circumstances. The following tables and sub-sections present the main themes that emerged within each of these three categories. In total, 96 respondents answered this question. Respondent numbers and percentages have been constructed in the same format as the previous tables.

5.3.1 Reasons for integrating existential themes into CBT sessions

A range of reasons were given for integrating existential themes into CBT, as summarised in table 17.

Table 17 Reasons for integrating existential themes into CBT sessions

Topic / theme	n	%
Existential themes come naturally; they cannot be ignored	8	8
Cannot see a way of providing therapy without touching on existential themes	6	6
Existential themes help patients to reflect and work through issues, and/or are evoked where they can bring meaning into people's lives	6	6
Works well in bereavement or trauma cases	6	6
Particularly effective for certain client types, e.g. teenagers and older people	4	4
Facilitates the development of a therapeutic relationship	3	3

Offers a more holistic approach to therapy	3	3
Mindfulness approaches demand an existential input	3	3
Acceptance Commitment Therapy demands an existential input	2	2
Compassion focused therapy demands an existential input	2	2
Works well with anxiety or depression cases	2	2
Existentialism has been a major influence on the therapist and so is introduced frequently	1	1
Works best with 'third wave' CBT	1	1
Works well in a palliative care setting	1	1
Works well with issues of pain, suffering and/or self-soothing	1	1

A predominant theme across the comments relating to why respondents integrate existential themes into their CBT sessions reiterated what some had mentioned in response to the previous question; that it is an organically occurring process. It was also posed that, in some instances, it would be very difficult to discuss clients' presenting problem(s) without talking through existential matters, presumably because some issues require at least some acknowledgement of greater life questions or issues in order for people to move on with certain tasks (e.g. move on from the loss of a parent or child) which can lead to feelings of isolation and meaninglessness, and which typically demands that at least some attention is paid to a philosophical questioning and/or understanding of death and dying and one's role in the universe (Yalom, 1980).

As is specifically highlighted by section 6.1 above, therapists found that the real work of therapy, and something that can lend itself to existentialism rather than strict CBT, is holding clients' hands. The holding of hands is not meant to be patronising, but comforting and of the type that clients can feel safe enough to explore the very issues that surround the human condition and life, for instance: death, the meaning of life, how individuals can find closeness with others whilst still having to accept and work within the reality that our existences, however social, are still countenanced by our individual natures, and the fact that we exist in our own bodies and must ultimately confront what this means in terms of feelings of isolation (May & Yalom, 1989). All of this requires a deeper and less structured approach, which the respondents not only grasp but appear to appreciate as a means of assisting their clients as well as themselves, something evidenced by the comments of one respondent who noted feeling like a gardener, but a useful one helping to do the hard rather than light work associated with cultivating: *"So I did not feel like a gardener lightly raking the surface soil of a client's world - when the client actually needed to explore the deeper roots of their suffering and plant some seeds of hope and meaning that might actually bear some fruit in years to come."* .

Other respondents noted similar ideas, especially concerning the fact that whereas CBT can be quite effective in some respects, e.g. providing tools to address anxiety and avoidance, integrating an existential approach, with the aim of dealing with existential topics, helps to address the origins of many clients' fears, as opposed to merely being able to address clients' symptoms. In this regard, as articulated in the following three responses, there is a sense that CBT can not only be supplemented by existentialism, but also complemented by it. The language used by the first respondent in the below sequence is such that there seems to be an imperative need to not ignore these existential themes

that constantly appear and reappear in therapy sessions. One respondent commented that, "people cannot be understood by cognitions alone!", apparently trying to convey the idea that there is more to people than their thoughts and that CBT, as currently practiced, might not go beyond this sphere. There is something that connects people such as commonsets of occurrences, including death, for instance, that are likely to affect clients.

> *"These themes come up over and over and cannot be ignored - the therapeutic task is often to help people face rather than fight reality."*

> *"To ignore what may be at the heart of what is important to the patient may mean that aspects could be missed that could make a difference to their experiences in therapy and out."*

> *"Patients have raised anxieties about dying. Whilst CBT gave me the tools to work with the anxiety and associated avoidance, I felt I needed to integrate existential themes to more fully work with the patient's formulation."*

> *"I can't really see how one could practice therapy without touching on 'existential' themes - 'why are you here in therapy?' already touches on this theme."*

> *"I have always taken notice of existential themes in my work. People cannot be understood by cognitions alone!"*

Six respondents described how integrating existential themes helped patients to reflect on their lives and pointed out that this approach, rather than dealing with just the presenting

problems in isolation, often helped to highlight the meaning that exists in their lives, as noted below:

> *"If a client brings this kind of worries to a session I think there is real value in discussing, exploring and reflecting on these - they're important themes and should be thought about."*

> *"Existential themes provide a good template for cognitive restructuring and to help patients to reflect and work through issues such as ambivalence and anxiety about change."*

Another salient theme across the comments on this topic was how incorporating existential themes into the therapy is particularly helpful with specific cohorts or problems such as teenagers, those reaching certain milestones in their lives, the elderly, or in cases of trauma, bereavement, anxiety, depression or terminal illness. This demonstrates a means of diversifying the sub-groups to whom therapeutic treatment options can assist, something that historically has not been the case (Rathod et al., 2010):

> *"Useful with teens for school refusal, paranoia and eating disorders."*
>
> *"Many of my clients are in their 40's and 50's and have reached a stopping point where they are wondering what life is all about. CBT would never be enough at this point, in my experience."*

"I do use existential themes when people are at crisis points in their life - retirement, facing a fear of death (which can come up with patients who have anxiety or depression), becoming a mother, caring for others."

"On occasion this has been helpful, particularly with bereavement work or trauma work in terms of a validation of 'what is'. It has also been helpful when working with anxiety clients using CBT since the treatment requires the client to acknowledge the idea that life is uncertain."

"I work as a supervisor and occasional therapist in palliative care, specifically with Macmillan cancer care. I have used an integrated form of existentialism and CBT to help both medical colleagues and patients manage issues of terminal illness."

Three respondents specified that the introduction of existential themes to CBT had helped them to develop a better therapeutic relationship with their clients, whilst a further three described how the inclusion of existential themes provided a fuller, more holistic therapy for the client:

"I believe an understanding of existential themes and their application to client work is essential to the co-creation of an effective psychotherapeutic relationship and a 'safe' context within which client issues can be explored and clarified."

"I find that the existential questions arise in the intimacy of the therapeutic relationship. Without these being explored, no CBT issues can be addressed."

"I believe that we are more than the sum of our thoughts, feelings and behaviours. Experience as a counsellor has taught me that clients find a holistic approach valuable, and often the most accessible for them. CBT does not always address the themes presented."

"The problem with CBT alone for me is that it lacks a depth that existential themes can partially add to."

Two specific types of therapy were mentioned as being in use: Yalom's therapy and Acceptance and Commitment Therapy (ACT). Moreover, those who use meaning-based therapies indicated that they found this especially useful in dealing with bereavement and trauma issues. Asked why they use or would introduce existential techniques into their therapy sessions, the most frequent response was to achieve a better therapeutic outcome. Moreover, it is likely that what can be inferred beyond this "better therapeutic outcome" assessment is that clients can ultimately lead sustaining psychosocial and emotional recovery, especially following bereavement, well into the distant future without having to continuously seek out a step-by-step approach to doing so. Arguably, this points towards the ability to sustainably address one's issues independently as the ultimate objective of therapy and the use of existential tools.

By utilising an existential approach, the skillsets learned and employed become a permanent part of the client's narrative, rather than merely something to be borrowed from the therapist. There is ownership and thus liberation that the client will be able to use those skills and knowledge gained well into the future. Conversely, the main reason for not integrating the two techniques was lack of training in meaning-based techniques. The following section elaborates on other reasons for the latter.

5.3.2 Reasons for not integrating existential themes into CBT sessions

Those who did not integrate existential themes into their CBT sessions explained why this was the case. Their responses are presented in table 18.

Table 18 Reasons for not integrating existential themes into CBT sessions

Topic / theme	n	%
Have not been trained in existential therapy	12	13
CBT is essentially about skills training and requires a level of superficiality not compatible with existentialist themes	6	6
Not within institutional (or IAPT) and/or NICE guidelines to employ existential therapy	3	3
Patients do not request this level of engagement	3	3
Existential themes are not usually relevant to the problem (e.g. too theoretical rather than practical, can seem 'frivolous' to be raising existential concerns in some contexts)	2	2
Not able to do so due to demands and time pressures of their role	2	2
Inappropriate to mix therapy with religion	1	1
No benefit in engaging with existential themes, there are no answers	1	1
Not culturally appropriate for the particular client group (First Nations)	1	1

The most prevalent reasons given for not incorporating existential themes into CBT sessions were a lack of training in this area and perceptions that the two approaches are

not compatible. Unlike some of the aforementioned comments made by respondents, responses to this question alluded to an acknowledgement that greater training could bridge the gap and lead to greater use of existentialism. In addition, it was also stated that, whilst each individual must address existential issues in their life, not all necessarily attend therapy to address such issues. Therapists must be mindful of addressing that which clients are willing and prepared to address in the moment. This can still lead to helping clients confront their issues, but in a manner that may be more in keeping with CBT than existentialism. These thoughts were articulated in the following comments:

> *"I would very much value the opportunity to do so but do not feel competent as have not received training."*

> *"I do not have the skills/training to integrate these themes. I would like to work more in this way but this is not in my remit currently."*

> *"I find it hard to do justice to existential concerns in my CBT role."*

> *"I can recall having touched on these issues when raised by patients in sessions, though I haven't elaborated on these as I don't feel I have the necessary training. Furthermore, I am not sure how this would fit with maintaining fidelity to CBT model."*

> *"CBT is essentially about skills training, rather than addressing the big questions. The same applies to 2nd wave and 3rd wave C&B psychotherapies. Even if you take the view that all phobias are ultimately about death, and fear of dying, the*

therapeutic approach taken in CBT is to desensitise by exposure to the fear, and even if it's at a cognitive level it's probably in a superficial way, rather than with exploring any attendant meanings in an existential way. Stick to the instructions and let the therapy do what it says on the tin."

There were also echoes of similar concerns in their responses to the first open-ended question regarding employing existential techniques within the somewhat rigid clinical frameworks and guidelines that many respondents have to adhere to:

"I would like to explore this more with clients but in an IAPT service must work in a way which is in keeping with my role as a CBT therapist, so scope is somewhat limited."

"Institutional hostility to using approaches that are not in the NICE guidelines."

Three people suggested that there is little client demand for an existential approach to therapy, whilst two respondents stated that they would be cautious in introducing existential themes in the context of problems that require a practical approach. Such caution was brought about by their fear of appearing to trivialise the presenting problem(s), which is an interesting comment since existentialism is often associated with deepening rather than making an issue superficial and thus trivial (Beck, 1976; Beck 2011).In such cases, existentialism may not be warranted at the time and may, in fact, cause more harm than help (Gabbard, 2009):

"Clients tend to request symptom relief and want specific tools and techniques to address this. They actively request a therapy that is different to counselling, a

'doing' therapy. They seem to like the concept of structure and action to tackle their problems. The vast majority of my clients don't ask 'big questions'."

"It has rarely been the explicit topic my patient has raised. I have referred them to other therapists or counsellors in the few times it's happened."

"Part of me also feels that sometimes these issues are rather comfortable and 'middle-class' - and that if one is focused on trying to avoid being beaten to a pulp by a violent partner or simply getting money to feed your kids, the themes of mortality, meaning, ex angst etc. can seem a little irrelevant."

5.3.3 Reasons for integrating existential themes into CBT sessions only under certain circumstances

In their comments, some respondents explained that they would only introduce existential themes into their CBT sessions in particular situations, their reasons for which are summarised in table 19.

Table 19 Reasons for integrating existential themes into CBT sessions only under certain circumstances

Topic / theme	n	%
Only introduce existential themes where it is relevant to the presenting issue and/or where the patient raises them	24	25
Existential themes tend to only occur after the presenting problem has been dealt with	2	2
Have not introduced existential themes - no reason given	2	2

The vast majority of those answering this question explained that they would only work on existential themes where it was particularly relevant to the presenting problem, and/or where the patient or client raised such issues themselves. By doing so, they, primarily wanted to stay focused on that which the client had brought in and/or was regarded as more beneficial, and to prevent the client from feeling unprepared for the therapeutic work, and thereby incentivised adherence (Gabbard, 2009), something mentioned earlier and supported below:

> *"Yes, because people do bring them so I discuss them with clients. CBT doesn't do everything nor does it pretend to."*

> *"It depends on the client and the context of their presenting problem(s). Sometimes it may be unhelpful, e.g. an anxious client with death phobia and intrusive thoughts might be better counselled to think less about existential themes. On other occasions, e.g. career crisis, bereavement etc., it may be helpful to consider existential themes."*

> *"If existential themes have come up I have explored them with clients; if it is an issue that is bothering/distressing them particularly in relation to deaths of loved ones and the issues of death this brings up for them. Also, in my work with people with developmental trauma issues, relating to the spirit of humankind can be touched on and the struggles to make sense of why the abuser abused, etc. The motives for exploring it is that it is an issue that clients are distressed by, and they don't always have anyone to talk to about them, and maybe sometimes some beliefs benefit from reframing or emotions validated to help them move on."*

"If clients are bringing existential themes or questions into the work then I will open up discussion of this if I feel it is useful for them. I would not do this if I felt it wouldn't benefit the client."

Two respondents explained that they tend only to introduce or discuss existential themes after the presenting problem has been dealt with through CBT:

"I think 'existential' themes do often occur, but more often when the everyday difficulties of the 'presenting problem' have been resolved (usually via CBT), and then deeper levels of despair, meaning etc. crop up."

5.4 If you would consider integrating existential themes into your CBT sessions in future, what would you hope to achieve by doing so?

There were two main elements to the responses to this question. The first was a recounting of what respondents hoped to achieve if they were to integrate existential themes into their CBT sessions. The second theme comprised a range of other comments relating to why respondents might not be keen to integrate existential themes, and/or any other concerns they had about integrating the two approaches. The following two tables and sub-sections report the topics covered within each of these two themes. In total, 74 respondents answered this question, with their responses quantified as before.

5.4.1 Anticipated outcomes of integrating existential themes into CBT sessions

Table 20 summarises what respondents hoped to achieve by integrating existential themes into their CBT sessions.

Table 20 What respondents hope to achieve by integrating existential themes into their CBT sessions

Topic / theme	N	%
Meet clients' needs / improve therapeutic outcomes	17	23
Encourage clients to explore their own beliefs and values	9	12
Place more emphasis on meaning and finding meaning	8	11
Enhance clients' understanding of the complexity of life and living	6	8
Provide a more holistic approach	5	7
Foster a better therapeutic relationships with clients	4	5
Aid an improved perspective on death and bereavement in clients	3	4
Provide a deeper exploration of existential therapy and its potential benefits for clients	3	4
Enhance clients' quality of life	3	4
Duty of care	2	3
Personal satisfaction in being able to explore wider issues	2	3
Ability to assist with presenting problems that do not entirely fit the CBT model	1	1

As might be expected, the most frequently cited and hoped-for outcome was that of meeting clients' needs, and/or achieving better therapeutic outcomes:

> *"I would hope that the help I provide clients would go beyond helping them to function and towards helping them achieve their true potential given their personal circumstances and attitude, beliefs and aspirations."*

> *"I believe I would achieve a stronger sense of purpose and meaning for clients who have a more existential arm to problems such as fear of dying, lack of purpose or meaning, extreme 'unfair' experiences of suffering. Although CBT might provide an improvement in functioning with these difficulties, I have sensed that the client (or maybe I have felt) has felt 'short changed' having not been able to explore more abstract difficulties."*

> *"I would certainly incorporate these themes into my practice if required by the patient's formulation in order to offer the best treatment possible."*

Linked to this topic were several comments suggesting that a major motivator for introducing existential themes was to foster better therapeutic relationships with clients (Dryden, 2009). Three respondents also suggested that they would hope to enhance the client's quality of life by introducing existential themes into this relationship:

> *"To make the sessions more meaningful, warm and personal to the client."*

> *"Hopefully the patient would have a deeper and more meaningful experience. They may feel heard and understood in a unique and different way."*

"A more rounded approach - helping people to live fully rather than just reduce symptoms."

Several respondents commented that they would hope to help clients explore topics such as meaning, beliefs, values, living and the complexities of life as part of their therapy through the introduction of existential themes (Yalom, 1980):

"More holistic approach to mental health - integration of the person in his/her world. Drawing attention to values, meaning, purpose in life, meaning of life for the individual and the whole from which they come."

"Helping the client have a broader understanding of life, its meaning and their role in it, but only if they wanted to explore this."

"Directly exploring existential themes and big questions with people who want to do this and with those for whom existential/identity/meaning issues are contributing to their depression and/or anxiety problems."

"I believe it is more authentic and honours the clients' beliefs - I may not go along with their belief system, but this does not mean we cannot talk about their beliefs and work out something that enables them to progress forward in a meaningful way."

5.4.2 Other comments on integrating existential themes into CBT sessions

As well as describing what they hoped to achieve by integrating existential themes into CBT, some respondents raised other issues in response to this question, as summarised in Table 21.

Table 21 Other comments on integrating existential themes into their CBT sessions

Topic / theme	n	%
Would need further training to integrate existential themes into CBT	9	12
Already integrating existential therapy into CBT sessions	4	5
Would need reassurance that it is proven to be useful	3	4
Would not consider integrating existential themes into CBT - no reason given	2	3
Yes, would consider integrating - no further explanation given	2	3
Due to retire so will not continue to integrate	1	1
Willing to discuss the issues during CBT but wouldn't say it is 'existential therapy'	1	1

Respondents' most frequently cited issue (featuring in nine responses) was the view that they would require additional training in order to be confident in integrating existential themes into their CBT practice, effectively demonstrating perhaps a sensed vulnerability amongst therapists that they could be better prepared to aid clients and they would like to be better prepared, much in the same manner as Deurzen and Adams (2016) noted clients must be prepared, in their own unique ways, for the work of therapy.

"I would consider integrating existential themes into my CBT practice but frankly, without further training and supervision to guide me, I wouldn't know where to start."

"I would consider doing this if I was trained and the approach was approved by my service, and would hope to achieve a broader range of therapy skills which may be of benefit to clients."

"Unsure if I would actively integrate, mainly due to lack of knowledge of this type of approach."

Four respondents explained that they do already integrate existential themes into their CBT, whilst a further three explained that they would need a better 'evidence-base' proving the usefulness of such integration before they would attempt to incorporate it into their practice; an understandable approach especially if, practically speaking, such sessions are NHS-sanctioned/paid for and may require reporting on more objective metrics rather than subjective ones (Cooper, 2017):

"I plan on continuing as before. I think of CBT as a dialogue, in which I am a resource to my client in working on their problem, using CB theory, formulations and techniques. That resource includes existential aspects of myself and my experience, and my approach acknowledges my client as a being with existential aspects."

"I would have to be persuaded that this would make definite benefits to clients."

"I am always happy to integrate new approaches where they have been proven to be useful."

5.5 If you have any further comments, please provide them below

The final open-ended question asked for any further comments. Table 22 summarises the topics mentioned. In total, 32 respondents answered this question.

Table 22 Further comments

Topic / theme	n	%
Keen to learn more about existential therapy and integrating it with CBT, e.g. via training courses, workshops, etc.	9	28
Praise for this research and the issues it is exploring / interest in finding out more	6	19
Comments on the survey questions, e.g. further elaboration of responses or details of difficulties or conceptual problems in answering some questions	5	16
Existential therapy is not the only approach concerned with meaning, many others also focus on meaning	2	6
Extent of the use of existential themes depends very much on the needs of individual clients	2	6
Tend to integrate CBT with any of a range of other approaches - not just existential	2	6
CBT is effective and there is not always a need to integrate other themes or approaches	1	3
Concerns about rigid IAPT approach	1	3
Current practitioner role in primary care not in keeping with existential therapy, so they are unable to undertake further training into this	1	3

Engaged with existential theme mainly at an intellectual level rather than it shaping their practice	1	3
Feel limited by having to adhere to an 'evidence base'	1	3
Interest in existential themes has developed throughout career - now keen to encourage younger colleagues to discuss these issues	1	3

Nine of the respondents who provided a 'further comment' explained that they were very interested in the issues around integrating existential approaches with CBT, and most were keen to find out more via courses or workshops. A further six respondents expressed interest in, and praise for, the topics covered by this research. Such intellectual and philosophical curiosity about the subject matter suggested that there is a real desire to add more to the current toolbox that CBT practitioners use in order to open up greater possibilities for clients, possibilities that can only exist by taking a more holistic and customised approach to treatment, something that may certainly, however, run afoul of the bureaucracy of NHS-sanctioned psychotherapy (Cooper, 2017):

> *"I would be interested to know more about how to integrate existential themes into CBT and would be keen, for example, to attend an introductory workshop on the subject."*
>
> *"Whilst I believe it is important to integrate existential themes into CBT, there is limited information and training on how to do this effectively. I still feel a novice in this area and believe further research and guidance in this area would benefit many therapists and patients."*

"I am really interested in finding out the results of the survey and find that all the questions I have asked myself as a therapist and human being over the years are being shared in research such as this, if that makes sense."

"Good luck. We all know that CBT often makes good sense but is not a panacea."

Five people used the 'further comments' box to comment on the survey questions or to provide further elaboration of their responses to earlier questions. The first response listed below is quite interesting because there is a focus on the therapist himself, rather than the use of existentialism in aiding one's client, perhaps signalling that before a therapist will utilise such an approach with clients, he must first deem it appropriate or worthy for use with himself. In addition, some struggled with what "existential therapy" meant, for themselves and/or in the survey they were answering:

"I'm not sure that I am clear about what you mean by existential: issues of death, after life, identity, 'meaning'? I had a sense that the questions on existential approach didn't quite fit me so, in some ways, didn't feel meaningful."

"Some of the questions seem to presuppose what existentialism is, questions of life after death, the universe etc. all seem to spring from a dualist tradition and existential thinking is broader than that."

Other topics mentioned in this final open-ended question tended to relate to a range of issues (many of which had been raised in response to the earlier open-ended questions),

and were mentioned by only one or two respondents each. They were included in the table.

5.6 Integrated discussion of survey Quantitative and Qualitative Reponses

The purpose of this research was neither to critique CBT nor advocate the integration of existential concepts with fundamental CBT practices. Rather, it was to help identify the state of practice regarding the mixture of cognitive behavioural therapy and meaning-based existential therapies and use results to shape a cohesive approach that better serves the patient's needs. These results add to the body of knowledge on this subject and expand on what has been reported previously by others.

As previously mentioned, the study included two survey components: the online survey and the interview-based survey. The following results stem from some of the key observations and conclusions that emerged from the online survey component of this study and were reported in this chapter.

5.6.1 Flexibility extends the applicability of CBT to more areas of need.

The CBT-S scale found that the majority of respondents 'strongly agreed' or 'agreed' that they felt comfortable in freely adapting the CBT techniques learned during training. Additionally, most 'agreed' or 'strongly agreed' that they already integrated other therapeutic approaches (psychoanalytic, existential, systemic etc.) in their CBT practices. These findings are supportive of McCracken and Morley (2014), who reported that a 'psychological flexibility model' that integrated cognitive and behavioural principles with an existentialism-oriented approach extended the range of applicability of cognitive behaviour therapies. Consistent with Scott (2011), these findings also suggest that

practitioners have an awareness that some of the inflexible structures employed in CBT are not appropriate in either the diagnosis or the treatment of more complicated cases.

As a case in point, one survey respondent stated that: *"Whilst CBT gave me the tools to work with the anxiety and associated avoidance, I felt I needed to integrate existential themes to more fully work with the patient's formulation."* Generally, respondents affirmed that cognitive behavioural concepts were very useful, but that the therapist could also benefit from the use of allied therapies when the situation calls for it. In one case, however, a respondent noted that his personal and professional focus for years has come from existentialism and so, whilst he practises CBT, an existential approach is always present in some manner, whether "explicitly or implicitly". This is articulated in the following comment:

> *"My inspiration to become a clinical psychologist and psychotherapist came from existentialism, specifically initially (and continuously) from the philosophy of Jean-Paul Sartre, and particularly from Being and Nothingness. It has been the bedrock of my entire approach to psychotherapy, and one reason I was drawn to REBT in particular was that it fitted best into an existential approach, and existentialism was indeed an inspiration for the early Ellis. Much of the therapy I have done over 40 years as a practitioner has been influenced by existentialism, either explicitly or implicitly."*

Conversely, two other respondents, whose comments (provided below) also centred on the benefits of existentialism, mentioned that it is only introduced when clients seem to be ready and perhaps even willing to engage such a fluid approach.

"I've read a number of books as well from people like Rollo May so they add another dimension to understanding others' perspective, but I consider CBT as mentioned above as a part phenomenological approach, so it's essential to see the clients experience from their perspective and not our own view. So, if we make assumptions in a quick formulation, this should always be checked out by the patients' experience/beliefs/data. I think for people's health there probably needs to be some philosophical questions and sense of meaning in the wider perspective - to do with belonging as many people feel a sense of anomie or alienation and CBT can help acknowledge this and help people become motivated to explore avenues but is limited - mindfulness probably helps here."

"If clients are bringing existential themes or questions into the work then I will open up discussion of this if I feel it is useful for them. I would not do this if I felt it wouldn't benefit the client."

In conclusion, many participants advocated and combined into their CBT practices other therapies, that is, adopted a flexible approach to CBT – often if and when the clients and/or themselves thought such combination would be advantageous to clients. Namely, existentialism was sometimes utilized at the outset, due to the psychotherapists' own inclinations, or regarded as necessary:

"I can't really see how one could practice therapy without touching on 'existential' themes---'why are you here in therapy?' already touches on this theme."

"I believe an understanding of existential themes and their application to client work is essential to the co-creation of an effective psychotherapeutic relationship and a 'safe' context within which client issues can be explored and clarified. When supervising or training other therapists, I would always seek to assess the level of existential/phenomenological practice my supervisee/trainee was employing in seeking to understand a client's perceptions and values in the clearest way possible."

5.6.2 Traditional, fundamental cognitive behavioural therapy is not the most appropriate therapy for all issues

The CBT-S scale also found that only about a third of respondents felt comfortable or would feel comfortable using CBT techniques with clients without regard for the particulars of their issues. Two thirds thus considered that CBT should only be used in a manner that respected clients' presentation. This suggests that flexibility was regarded as beneficial, but also that CBT be insufficient and unable to adequately address each one of the clients concerns:

"I can't really see how one could practice therapy without touching on 'existential' themes---'why are you here in therapy?' already touches on this theme."

"I believe an understanding of existential themes and their application to client work is essential to the co-creation of an effective psychotherapeutic relationship and a 'safe' context within which client issues can be explored and clarified. When supervising or training other therapists, I would always seek to assess the level of existential/phenomenological practice my supervisee/trainee was employing in

seeking to understand a client's perceptions and values in the clearest way possible."

This is a similar conclusion to Kingdon et al.'s (2010) that stated that cognitive behavioural therapy was not the answer to all mental health problems. However, in the case of this research, there is a rather drastic difference between what certain scholars argue and what the respondents themselves indicated. The literature points towards a divergence from exclusive use of CBT but that is not truly captured in the data.

In the literature, some also believe that Person-Based Cognitive Therapy (PBCT) and Mindfulness-Based Cognitive Therapy (MBCT) were developed out of a perceived short-coming of CBT (Crane, 2008; Segal et al., 2002). Parrott and Tan (2003) go so far as to say that CBT is in risk of becoming a mechanistic and prescribed system that is not adaptable to a client's specific situation. This view is shared by a participant: *"Experience as a counsellor has taught me that clients find a holistic approach valuable and often the most accessible for them. CBT does not always address the themes presented."* The current research findings of this study supports the same notion in that, whilst the vast majority of respondents agreed that they were overall satisfied using CBT, 44% also already have pursued or intend to pursue knowledge of meaning-based approaches with an intent to integrate them with CBT practices. There seems to be little doubt, therefore, that there exists the recognition amongst them that CBT is not appropriate for every client issue and concern, but that the therapist must provide the best treatment for the client, even if it means introducing another model for therapy.

This was further borne out in the open-ended responses, where the following was noted:

> *"I try to integrate existential themes into my CBT sessions whenever this is a vital dimension for understanding how the client experiences his or her problems and for helping him/her. Clients appreciate this very much."*

> *"If it is important to the client, then I will integrate these themes within a CBT framework."*
>
> *"To ignore what may be at the heart of what is important to the patient may mean that aspects could be missed that could make a difference to their experiences in therapy and out."*

In these responses, there is a dynamism at play in which the respondents appear to note how they let themselves be led both by their clients' needs and wishes as well as their fiduciary duty to provide the best care. They exist on the same plane and sometimes must be painstakingly evaluated simultaneously, perhaps during sessions rather than as the consequence of reflection after them. As a result, this ability to truly counsel is framed by the continuous information that clients provide the therapists and the rapport that has been established. In this case, the therapists' approach is not only adapted to the issue itself (namely, existentialism for existentialist issues) but to the client, who brings it along and manifests an interest in discussing it.

5.6.3 CBT and existential themes are considered complementary-with-caution by some practitioners.

Overall, the questionnaire scale responses show that 47% agree or strongly agree that existential themes are vital, and that 67% don't steer clear of "big issues," even if they are

using CBT methods. Despite the fact that**,** philosophically, many respondents agreed that CBT needed to be supplemented with another meaning-based therapy in order to deal most effectively with existential issues, their combined questionnaire and free responses indicate that CBT practitioners who are not trained in existential therapies may avoid their use until they feel properly qualified to do so. This, in tandem with self-doubt that emerged in the free responses regarding maintaining 'fidelity' to the CBT model if attempting to integrate other approaches without due training, compounds the complementarity-with-caution attitude displayed towards integration.

A therapist's willingness to delve into existential matters may also depend on their personal belief system and professional needs and inclinations. This may be another aspect of the professional career progression that Edwards (1990) alluded to when he suggested that the therapist could start out in the profession as a CBT specialist and then, by acquiring the appropriate communication skills, move on to the role of the phenomenological existentialist therapist. The findings here suggest that existential therapy requires a different skillset, or at least mentality and knowledge, than traditional CBT because it encourages and aids the patient to change his or her philosophy of life, rather than focus on the substitution of negative thoughts and behaviours for positive ones.

> *"I think it helps to address the complexity of life and living."*
>
> *"CBT does provide immediate 'first aid' but not a deeper level of understanding about the 'human condition."*

> *"However, life isn't a series of paths and goals and wrestling with existential themes becomes increasingly important, as life progresses. Many of my clients are in their*

40's and 50's and have reached a stopping point where they are wondering what life is all about. CBT would never be enough at this point, in my experience."

It also appears that there is a possible recognition that meaning-based therapies require a different, more complex, skillset than does CBT. This could explain why 44% of the respondents 'agreed' or 'strongly agreed' that they already had or were going to seek additional existential training and/or integrate existential themes into their practice. Since the majority of respondents were CBT certified therapists, it is also possible that they rated existential items lower because they did not understand or accept these concepts as well as they did the CBT items.

5.7 Conclusions

There seemed to be little doubt amongst these respondents that CBT and meaning-based therapies require some different values, beliefs and assumptions about the nature of cognition, behaviour, and mechanisms needed for dealing with life's challenges and issues. These perceived differences accounted for which issues the therapist chooses to treat, and the methods employed in the plan for treatment. The lack of complete satisfaction with the adequacy of any single methodology leads to a belief that multiple treatment methods are needed. Moreover, these were often, and perhaps should be selected based on the issues presented by the client. The option to integrate CBT and existentialism may also be beneficial because it provides both medicalised and non-medicalised modes of client care that are based more so on empowering the client, rather than empowering the therapist whilst focusing on the client.

In the same community of traditionalist as well as more hybrid-approach oriented practitioners, there are those who feel that there are emergent social issues that require different solutions. There appears to be an increasing upsurge in the search for new therapies and new adaptations of existing ones. The blending of complementary therapies (such as CBT and existential approaches) seemed to be a natural fit, at least in some instances. Whilst they are based on some different fundamentals, they are not demonstrably inimical. This research is perhaps the beginning of a new wave of research that establishes the need for the co-evolution of CBT and existential therapies.

5.8 Limitations

As noted earlier in this thesis, this phase of the research was limited in certain ways. Firstly, the survey instrument could not be piloted due to time constraints, which arguably may have impacted the extent to which the items could have been more masterfully conceived or presented upon conducting the complete study. Secondly, even though therapists who practise CBT in the UK can relatively easily be researched using various organisational sites, etc., there is no accurate way of ascertaining the number of therapists who practise CBT, so as to have a truly representative sample size. In that regard, even if a statistically high enough sample size was obtained, there would still be the limitation of not being able to accurately generalise the collected data. Thirdly, though content and thematic analyses are often appropriate and comprehensive techniques to understand qualitative data, such as that which emerged from the free responses, it is also true that such an analytical approach can fall vulnerable to the underlying beliefs, value systems, and even prejudices of the researcher. To overcome this, at least in part, an acknowledgement of this limitation is needed, as well as extra consideration from trusted colleagues to look over the data, which was obtained in this case.

Chapter 6 – IPA Analysis ('qualitative strand')

An Interpretative Phenomenological Analysis (IPA) of Existential Attitudes Among Cognitive Therapists

6.1 Introduction

The literature review showed the existence of a simultaneous disconnect between CBT and ET and also great potential for integration between the two. This chapter examines the latter issue as based on the insights provided by eight CBT therapists' descriptions of their experiences of using existential components within their practice. In-depth interviews were conducted with these participants and subsequently analysed using Interpretative Phenomenological Analysis (IPA). Specifically, the aims were:

1. To understand how therapists incorporated existential components within CBT.
2. To explore therapists' specific experiences of using or attempting to use ET in their practice of CBT.

Table 23 Master Table of Themes and Sub-themes

Main theme	Sub-themes
Assertion of the Human	Superficiality versus depth
	Structure versus fluidity
	Client presentation and preferences
	Power dynamics
	The wounded therapist
Missing Elements	Theoretical and practical gaps
	The 'human' gap
	The authenticity gap
	The 'meaning of life' gap
	Gaps in existentialism

Integration in practice	Personal and professional background The unsystematic nature of integration The therapeutic relationship

The IPA resulted in the identification of three main themes and a number of corresponding sub-themes, which are summarised in Table 23. In broad terms, themes one and two relate to the participants' general experiences of using or attempting to use ET in their practice of CBT (Aim 1), while theme three relates to the specific ways in which these ET were incorporated within CBT (Aim 2).

The participants consisted of five men and three women, aged 31 - 74. They represented a variety of work settings, including IAPT, private practice, and secondary care. Table 24 provides details of each participant's personal and employment characteristics, with the use of pseudonyms to maintain their anonymity.

Table 24 Participants

Transcript code	**Name**	**Sex**	**Age**	**Specialty**	**Current role/title**	**Years accredited CBT/REBT**
0004	John	M	48	CBT REBT Person centred	Consultant clinical psychologist and senior lecturer in CBT	21 years
LS110462	Robert	M	74	CBT REBT	Retired consultant clinical	47 years

				Person centred	psychologist and honorary associate Professor	
LS110563	Stuart	M	56	CBT ET	CBT therapist with IAPT	8 years
LS110508	Graham	M	56	CBT Integrative	CBT Therapist and trainer with a support charity for the terminally ill	15 years
LS110594	Mark	M	60	CBT Phenomenological	CBT therapist in private practice	26 years
LS110602	Joanne	F	45	CBT REBT Spiritual	Clinical psychologist specialising in psychosis	15 years
LS 110608	Karen	F	46	CBT EMDR	CBT therapist specialising in PTSD	16 years
LS 110611	Ann	F	32	CBT ET	Counselling psychologist in private practice and IAPT	4 years

6.2. Assertion of the human

This theme reflected the perception conveyed by many of the interviewees for ways in which CBT could lack a sense of humanity and could be seen as "cruel" while ET enabled the therapist to assert a humanistic approach. ET was often posed as a *'stand-in'* for a whole set of ideas that expressed the feeling that there was something missing from CBT that was seemingly conceptualised by interviewees in terms of a path in reaching out to the clients' humanity. This was central to how the research participants associated CBT and ET in their minds.

Given the centrality of this 'assertion of the human' and the possibilities it offers as a means of bridging the gap in practice between CBT and ET, this theme was deconstructed into five separate sub-themes (see Table 1), that aim to achieve a fuller, deeper analysis. These sub-themes are defined as superficiality versus depth; structure versus fluidity; client presentation and preferences; power dynamics; and "the wounded therapist". The following sections present and discuss each of these in turn, with verbatim examples from the interviews to illustrate the key points from the personal perspectives and lived experiences of the research participants.

6.2.1 Superficiality versus depth

The first sub-theme reflects the ways in which the participants discussed their perceived differences in the "depth" of CBT and ET. CBT was in various ways described by respondents as superficial, and ET as having more depth. This impression derived from the contrasting terms that were used in the interviews when referring to each modality. For example, CBT was discussed in terms of being "*aimed at the superficial*",

"practical", "a quick fix", and "simplistic". Conversely, ET was expressed by the participants as being what lies at the core of a person. The contrasting terms used when discussing this approach included *"meaning of life", "long-term", "complex", "contextual", "dealing with big questions", "understanding", and "more creative"*. Frequently, this perceived dichotomy between the superficiality of CBT and the depth of ET was directly expressed in the interviews. For example, Robert notes that while CBT *"sometimes [may be] all that's needed*", it nonetheless "*demolishes a number of common assumptions, which are at the root of emotional disturbance."* He then contrasts this with ET, commenting that: "*no other approach quite approaches this … for providing depth for what can often be quite a superficial form of therapy – CBT.*"

Ann explains the perceived depth of CBT in terms of its logical, step-by-step approach, which contrasts with the more exploratory, contextual, unstructured nature of ET, and can tell us what is happening but not why:

> *With CBT, if you can answer what's on the page there's a sense of achievement but also most likely what's on the page isn't going to be the most arduous. It's going to be time consuming but in terms of digging deep, the questions and what you have to do is a logical construction of argument and that's very philosophical in itself, argument, but is basically, this is A, this is B, this is C, this is the link, can you see the link. Yes, I can. Okay, well, so, if you can see the link, how do you apply it? Well, I can apply it. So it's nearly like, I don't mean a mathematical structure but some aspects of it are like that, and in that way you lose actually anything else that's going on, because you're so concentrated on getting this*

structure right and having this piece of paper for the therapist to bring in the next day. (Ann)

Ann's reference to the client addressing *'what's on the page'* evokes a two-dimensional image of CBT - that of a flat page, rather than a three-dimensional, more complex structure that mirrors the workings of the human mind. From Ann's perspective, it seems that *'digging deep'* cannot occur within the CBT paradigm given its flat-surface start and end point. Interestingly, when elaborating on how she had enabled clients to *'dig deep'* by incorporating ET, Ann used terms which contrast sharply with the language of 'mathematics' and 'logic' such as *'metaphor' 'creative'* and *'interesting'*:

Delving a little bit deeper by using kind of things like the metaphors and … we'll do some creative things that they might find interesting that… I'd hope, would help them learn more about themselves. (Ann)

In highlighting the surface-level nature of CBT in a similar way to Ann, several participants observe a perceived schism between old or classic CBT/ REBT and contemporary CBT.

For example, John expresses the view that the current perceived superficiality of CBT is mostly due to the failure on part of the therapists' ability to grasp its philosophical origins and reflects a growing tendency in therapy to '*capture various techniques without understanding the origin of the theory.'* Similarly, Mark makes a distinction between past and present approaches to CBT. He describes traditional CBT as being holistic, concerned with personhood and transformation, open, and flexible. In contrast, present-day CBT is

described by Mark as being mechanistic, issue and specific-change focused, "*stultified and rigid*", and "*dangerous*".

Like the majority of participants, Mark links this development with the current UK context in which CBT is being delivered, notably its governmental expression named Increased Assess to Psychological Therapy (IAPT):

> *Well, perhaps the earlier approach of CBT was that it was more of a holistic approach in the sense that it was more aligned to perhaps the existentialist idea of somebody becoming something or it allowed for general change in a client as opposed to specific changes and I think that was much more of a psychotherapeutic approach but it is now, in many cases, lost.* (Mark)

Mark's observation regarding IAPT suggests that he sees the superficiality of CBT as something that has evolved owing to a political context that has constrained the original drive and paradigm of CBT. From this perspective, the depth that has been '*lost'* might be seen as a wider process in which CBT has changed not on philosophical grounds but, rather, on political and economic ones.

Joanne's views concur with those of Mark regarding the superficiality or simplicity of the IAPT approach to CBT. In her case, however, this recognition is reported to have been a driving factor in developing a more holistic, existential approach in her own work. In this sense she posits the political context that is constraining the holistic potential of CBT to also be its potential saviour:

I think that [working within an IAPT context] helped to solidify my ideas about the need for holistic approach to CBT because the IAPT is a very diluted, especially the lower intensity self-help, manualised. And in a way I think it's probably in some ways done CBT a bit of favour to highlight the danger of simplifying it so much that we lose the therapy, the art of the therapy and… that relationship, getting to know a person as an individual, being individualised formulations … I think being part of IAPT for a bit helped me to … say "… CBT is a lot broader than this and could be even further broadened". (Joanne)

What is unclear, therefore, is whether the overall consensus among the interviewees about the relative superficiality of CBT and the greater depth of ET is an accurate depiction of CBT and ET, or simply reflects a more general discomfort around the form of CBT that has become dominant in the UK in recent years.

As Joanne's comment above highlights, it is often the way therapists interpret and adopt particular approaches in their work that is more significant than the way these therapies are formally defined. In this context, the growing sense of dualism and the impact of political developments may potentially be leading to a greater interest among therapists in how the integration of ET could resolve the perceived *"superficiality"* of CBT.

6.2.2 Structure versus fluidity

In a sub-theme related to but subtly distinct from the depth and superficiality, the interview data revealed a contrast between the mechanic, symptom-focused, CBT-specific formulation models that are highly structured and technique orientated, and the

more fluid, relatively indefinable and unstructured approach of ET based on person formulation.

For some interviewees, the structured nature of CBT was perceived to be due to the rigidity of the technique while others attributed it to the way CBT has been adopted by the NHS. Recently, it has imposed measurable outcomes and a formal training process designed to ensure the rigorous application of this model.

Several respondents construed the CBT model to be overly prescriptive and rigid as a technique in itself, and highlighted the ways in which this limits its usefulness to the therapist and involves potential risks to the clients. For example, Joanne cautions: *"You're working with people and you're working with individuals, and I think that's the thing with CBT - there's a danger of a model to fit all.*"

In a similar vein, Stuart explains the practical difficulty of using this highly structured form of therapy in client sessions and emphasised that the perceived greater fluidity of ET flows naturally in the real life therapy setting. In his view, ET allows for a more organic development of both the client's problems or needs and the therapist's understanding of them:

> *Given that existentialism is all about the fundamentals of human existence it is going to be there in whoever presents. I'm not very good at following CBT models because I tend to want to listen to what the client wants to talk about. You're supposed to set an agenda with CBT. I've very rarely been able to do that, to actually sit down at the start and say "Okay, what's going to be on the agenda*

> *for today? What are you going to talk about?" because usually by the time I've got to that point they've already started. They start as they come in the door and then they're starting to talk about what their concerns are and I'm not CBT enough to say "Well, never mind all that stuff, what you were referred for is this, so what we're going to talk about is that."* (Stuart)

This is not to say that the participants uniformly derided the structure and technique-oriented focus of CBT. Instead, several noted that for some clients CBT is the most useful approach, while also emphasising the importance of flexibility in tailoring modalities to client needs which will be discussed further in the third sub-theme. For example, Ann observes:

> *You do learn 'rotely' how to do things and you can become very good at it and it certainly does help people at the basic level and certainly people use this and find that they never have problems, but some people use it when they find that it didn't work as everything.* (Ann)

By using language denoting a fixed form or function – *"static" and "rote/ly"* - in association with CBT, and contrasting this with signifiers of the non-fixed (i.e. *"fluid"*), Ann recalled the dichotomy between the two approaches in this context while acknowledging the potential usefulness of both in response to varying levels of need.

The view also emerged among other respondents, notably John, Stuart, Mark, and Ann, that there is a general tendency towards philosophical rigidity in all modalities because therapists increasingly adhere to one particular approach without considering others. This

indicates that the danger of a structured, rigid approach is not confined to CBT and again depends on the way in which the therapist applies the chosen modality in their practice. For example, John observes that over time, there is a tendency for therapy to become "*automatic*", "*motoric*", and increasingly rigid as therapists attempt to follow the set pattern of any one mode. In his interview, Mark points out the risks of a highly structured approach to therapy, regardless of the specific modality that is being used. He observes the negative effects that can occur if technique and formal protocols are followed rigidly by therapists:

> *There are some practitioners who just have technique and who are quite dangerous really because they can use a powerful technique without being able to deal with the consequences if it goes wrong. (Mark)*

This is reflected in the perceived dogmatic approach of key individuals associated with particular modalities, as Mark observes in relation to CBT. For him, it is important to retain a fluid approach to therapy regardless of the modality or modalities adopted:

> *Once the proponents - the key players, if you like, whether they be academic or whether they be practitioners - set themselves up as being gurus of a particular thing then it becomes a dogma and I think CBT has largely become dogmatic and that's not therapy in my eyes.* (Mark)

Stuart contends that even ET is becoming "cultish" and inflexible as its proponents focus on the benefits of this approach at the expense of others. Ironically, in light of his previous assertions that ET is necessarily more *'fluid'* than CBT, here Stuart implies that the nature of ET lends itself to a more rigid view of its own *'rightness'* in the sense of moral

superiority. That is, ET may become dogmatic and rigid when belittling non-fluid approaches, in the same way other approaches can become dogmatic when valuing a particular aspect that characterises them over another they do not profess.

> *I think personally there's a danger of all the therapy modalities that they can get a bit fighting for the moral high ground, you know, this one's right. This is the right way to do it, all the others are wrong. This one's right… so all therapies are a bit prone to being a bit cultish I think. I think existentialism has a tendency to that, just because it is so esoteric.* (Stuart)

In this sense, the structure and/or fluidity of CBT and ET are less relevant than the overall rigidity of the canon of thought positing them against one another, and people setting themselves up as authorities in a particular approach hinders the on-going adaptation and evolution of these therapeutic modalities.

On the one hand, almost all the interviewees observe the prevalence of rigid models, totalising theories and cultishness while holding up a model of thinking and working which is more fluid and permeable on the other hand. Mark, for example, discussed the importance of this more fluid approach in providing therapists with the flexibility to incorporate different modalities into their work over time, thereby favouring the integration of therapies in practice:

> *The moment anything is pinned down it loses some of its value and that, I think, is one of the attractions of keeping that fluidity in approach and also that capacity to be able to flex and to bring in new ways and maybe new sort of constellations of how things can be worked with.* (Mark)

Mark's use of the word '*constellations'* is significant here as it explicitly conveys the importance of a pluralistic and open approach, which does not pin therapists down to the use of one modality or another, in contrast with the "cultish" approach that several interviewees observe to be evolving. Karen similarly highlighted the importance of flexibility in incorporating multiple models, specifically within the context of the current NHS approach to CBT:

> *I really wish that the BABCP would embrace other models. It seems to be very – what's the word – not partisan, but CBT or nothing. It would be really good to look at ways of merging with other organisations and other models that the people use.… I just feel like we should be exploring more and learning more. Just because you've found something, don't stick with it, develop it, grow it.* (Karen)

Overall, there is a strong sense from the interviews that the research participants reject the use of rigid models in favour of greater fluidity, pragmatism, and adaptation. They often seemed to favour integrative approaches. This reveals another aspect of fluidity that can be distinguished from the lack of fluidity expressed in their descriptions of CBT as mechanic and (over)structured. They convey the sense of wanting to put themselves and particularly their clients, and not a theory or *"guru"*, at the centre of their therapeutic practice. This leads on to the next sub-theme, which highlights the ways in which client presentations are reported to have an influence on decisions about which therapy modality or combination of modalities to use.

6.2.3 Client presentation and preferences

Many of the participants reported that client presentation and their own responses to this affected their decisions about which therapy modality to use or how to go about combining modalities. This links with the overarching theme "assertion of the human" in relation to the personal, human aspects of the real-life therapy situations that are shown to play a role in the way in which CBT is combined with ET or other modalities in practice.

The interviews revealed that this is not necessarily straightforward. Several respondents observed that there is no single best way of judging how to use particular modalities in relation to client presentation. This was often implicitly connected with the idea of the therapeutic relationship. Those who indicated that they placed a high priority on this relationship seemed to struggle less than others when trying to categorise modalities according to presentation or clinical assessment.

There was a divergence about who should be the key responsible person for choosing the therapy modality. On both views, however, client presentation was critical. Mark, for example, expressed the belief that clients do not generally have a preference for one modality or another, and it is the responsibility of the therapist to determine their needs and select the most appropriate approach from the repertoire of *'tools'* available to the therapist. According to Mark, having more than one tool prepares the therapist to make the right judgement about which one to use rather than routinely employing the therapist's preferred modality, which may be inadequate or erroneous in relation to that client's needs.

The client doesn't care a hoot as long as they're being properly attended to and listened to and treated … it's rather like coming across a sort of really overgrown, gone to seed garden that's gone wild everywhere … and you have got to understand what the soil is in the garden, what the outcome is that the person wants the garden to look like at the end, what sort of things are appropriate and what aren't. Your techniques, your approaches, need to be left in the shed until you've worked all that out. (Mark)

While placing a similar emphasis on the client relationship and on understanding their needs, Karen makes the inverse argument that clients often do have strong views about their treatment and should be involved in the judgement as to which modality is ultimately selected. Karen explains that this is how her own approach differs from pure CBT, and highlights the importance of providing the client with the knowledge and understanding they need for choosing the therapy that most resonates with them.

I will take a lot longer now getting alongside someone, getting to know them than probably a CBT assessment would allow for. I mean, I would include that, but I would want to know how the person's thinking, feeling, just making sure that there's a good alliance … A few people have said, "Oh, nobody's ever explained anything like that before," this is another thing, that models don't get explained. One of my recent clients said she had CBT, but she didn't know what it was, because it wasn't explained. So it's again treating the client as an intelligent tier and explaining the model to them, so they understand it, how things work. (Karen)

Karen stated that she would let the clients choose modalities. Nevertheless, in the sense that she explained modalities to clients, she was also part of the choosing process. How the choice of modality could be a collaborative process was more explicitly described by Ann. She emphasised that the approach should be co-created by the client and therapist, taking into account the attributes of the client and the therapists' opinion about the suitability of different therapies for them:

> *You're creating the therapy between you… from a client coming into the room and whether they have been told that they need CBT or whether they're … people that know about CBT, have looked it up or have been told that they should be referred for it, and often within the first 10 minutes you'll know whether it will suit or not, or whether you have to do not a watered down version but actually a more complex version in joining the two, but at a different pace because it's just sometimes... for some people it's [CBT] too bamboozling.* (Ann)

Other interviewees were more concrete about which factors influenced their decisions about whether CBT and/or ET were appropriate, depending on client presentation. For example, Robert identifies the key deciding factors to be the depth of the client's problem and the extent to which he perceives them to be psychologically prepared for the profound questioning that an ET would involve. Observing that CBT can sometimes be appropriate for a *"fairly superficial problem"*, he also highlights that *"some people… are ready for the existential approach and some aren't"* and that some clients are resistant to or *"defended against"* ET.

Some of the other therapists talked about presentations of anxiety and how this could induce a degree of ambivalence in deciding on the correct modality. Graham, for example, expressed the view that CBT was often useful in presentations of anxiety, when the cause can be easily identified, such as work-related stress. He also observed, however, that when the anxiety was not easily identifiable, ET could be a better approach, particularly when dealing with anxiety around death, health, and bereavement. In discussing a case of depression in a terminally ill patient, Graham explains how in his experience a "*humanistic"* approach, including strong existential elements, had proved more effective than CBT and ultimately led the client to embrace and make the most of the remaining time. Graham's account of this case illustrates the way in which a dynamic approach was used to try out different modalities with a client in order to determine which resonated best with them and generated positive results.

> *We started with CBT. We then stopped that fairly quickly because he couldn't engage with the process. We then brought in some humanistic ideas to just kind of sit there and contain and hold it. We talked about why he was fearful of death and all of that, so that was where the existential bit came in and I would like to think that was the bit that he thought about, slept on, considered and then finally thought "yes, when I consider my life and what it means to me and other people, then this is something that I ought to do.* (Graham)

Overall, the interviews indicate that the choice of modality is frequently influenced not only by the type of problem that a client presents with, but also by the therapist's perception of the client's way of thinking, such as the extent to which they are 'philosophical' about the problem or their circumstances. Joanne, for example, compared

anxiety and depression, portraying those with depression as *"maybe ruminating on those big questions more",* whereas someone who is anxious *"just wants to get on with things".* However, as Ann noted, for those with PTSD, bereavement, and grief, their challenges might raise *'big questions as well'*. In contrast to Joanne, Ann regarded anxiety as more of an existential issue, with therapy being about *"sitting with that anxiety"*, and integrating CBT and ET from the start. That is, CBT was perceived by Ann as suitable for dealing with big questions – those which were commonly perceived as more suitable for ET.

The general impression across the interviews was that short-term alleviation through CBT could be more immediately effective for preparing clients for longer-term work. Robert explained his preference for CBT in this context with the following example:

> *Very often a depressed person will say "What's the point in me doing that washing up? It's so pathetic. It just proves yet again how useless and pathetic I am," but then if you help them to see that if I do nothing I am nothing, in a sense. There's this concept of self being not a thing but a process, then I construct myself through my actions in life.* (Robert)

Here, integration of approaches is built in from the start and is client-led, relating to understanding the *'process of self'* rather than the presenting issue *per se*.

In discussing the best modality to use with different client presentations, the interviewees sometimes appeared to contradict themselves, which seemed to reflect their own struggles with CBT. John, for example, discusses the difficulty of using ET with those who struggle

to access their internal world, those with less coherent verbal skills, those with strong spiritual values, and those with learning difficulties, but mentions for those with learning difficulties that:

> …[I] *have had a strong resistance to the idea that all that can be done for those people is very blunt behaviour modification because I don't think that that is true. Maybe what we need to do is spend more time refining our language to interface with someone else's language and their labels of emotion… I've yet to find a client who, at one level, existentially, you cannot make that connection with and then work with their frame of reference because it actually is more important to them, which, yet again, implies that you walk with the client in their internal world.* (John).

The contradiction is evident in the fact that, even though John begins by discussing the difficulties inherent to ET, he finishes by conveying its "*panacea-esque*" to all clients, with whom the connection can be made in an existential context because ultimately what matters is walking with them *"in their internal world"*. This *"walk"* implicitly, cannot be achieved through CBT alone, as John also emphasised: *'I move away from the whole symptom-based approach because I'm not sure that's relevant to people's lives.'* In a sense, then, he was also of the opinion that client presentation did not matter for modality choice; making the therapeutic journey alongside the client, which is more of an existentialist approach, was more important.

6.2.4 Power dynamics

Several respondents discussed, either explicitly or implicitly, various power dynamics that influenced the ways in which they selected and used different modalities in their work. These included, in particular, institutional power over the therapist, such as the way the NHS controls budgets; the power that a therapist holds over their clients; and the "power struggle" that can occur between proponents of different modalities. This is defined as a sub-theme of "assertion of the human" in the presentation of findings since power is an inherently human concept, and the findings reflect the importance of achieving the right balance of power in therapy.

Mark's reference to *'bucking the trend'* in the quote below signals a perceived power struggle between institutional forces that ultimately make CBT accessible to the public, the academics that try to preserve the non-mechanistic, organic nature of CBT, and the therapists who are seen to be succumbing to the institutional "power" that is driving this approach, implicitly supporting the therapy's mechanisation or *'computerisation'*:

> *There are certain academics who are sort of bucking the trend, if you like, but the mainstream, I find, has really almost taken psychotherapy out and it's just become a sort of mechanistic blueprint. I mean, it appals me that they're trying to get it up a computer now.* (Mark)

John, in contrast, conveyed the sense of an institutional power struggle between maintaining the integrity of the statutory services sector in offering CBT in the face of funding cuts, and outsourcing those services to the *'independent sector'* where clients, who then need to pay for them privately, will feel they have more leeway to complain if *'things aren't effective.'*:

> *The IAPT high-intensity CBT model … that's what's dominating IAPT. My suspicion is that actually there will remain people who use techniques and just apply those techniques. The cynical side of me says that actually I think the funding for those services will run out and then there will be a transitional phase where psychotherapeutic services move more out yet again into the independent sector and there will therefore be a far more greater likelihood that clients engaging with those services will be prepared to complain when things aren't effective if that's being offered.* (John)

In John's view, there was a conflict between wanting and/or needing therapy and being economically able to undertake it, and in particular via the NHS. More importantly, the therapist was in a double bind - if they stayed within the remit of the NHS, they needed to bow to the NHS's power in terms of complying with the high-intensity CBT model, with a focus on '*just techniques'*; if, however, they moved to the independent sector, they were envisaged to need to bow to private clients' power, whose right of complaint, as John suggested, would be more justified as they were no longer receiving the service for free.

John also expressed the view, however, that despite the more transactional nature of CBT in a private setting, it could help to *'sift out'* the inadequate elements of CBT (such as an overly rigid focus on technique) and thus restore to therapists the freedom to enact this transaction with private clients with improved autonomy:

I have less of a problem with the idea of independent practitioners because I think that's about valuing what it is that is done and I think that that will actually sift out perhaps a lot of those elements. (John)

John further spoke about how power intersects with therapy in terms of the client-therapist relationship, presenting the CBT therapist as '*an angry headmaster'*; the didactic nature of CBT as controlling with respect to the client:

I think [it's] actually quite desirable for the CBTs to acknowledge that the client is their expert in their internal world and stop trying to be an expert by applying the angry headmaster approach. (John)

John was the only one to use such strong terms in relation to this dynamic; while most other respondents recognised the potential '*danger'* of misapplying CBT and its *'power'* to hurt rather than to heal in those instances and emphasised the importance of an egalitarian power balance between therapist and client as the most desirable way to enact both CBT and ET. Furthermore, they did not recognise or describe the existence of a client-therapist power struggle over who held more knowledge about the client.

For example, Robert emphasised "*the genuineness and the importance of rapport"* as *"one of the most powerful ways of engaging a client",* while Karen highlighted her deliberately power-balanced approach in co-creating a client-tailored therapy:

The most important thing in any therapy is the therapeutic relationship, because if you haven't got that, if you haven't got those skills to be able to connect with

someone and form a therapeutic relationship very quickly, they're not going to come back, or they're not going to trust you, to open their heart up to you… If you've got those skills, you're halfway there. Then really the client is willing to trust you in terms of the models you use and the approach you take. (Karen)

Karen's emphasis on the fundamentally relational nature of the therapy evoked certain gentleness in the therapist's power over the client in her terms, *'opening the heart' and 'trust'* underlining this. In this sense, the therapist's power is seen as benign as it is, first and foremost, something that they have been granted permission to enact via the client's trust. Moreover, Karen's openness to consult with the client with the best approach recalls the humility mentioned when discussing empathy as a way of accessing both the client's and therapist's uniqueness, which further adds to the sense of power balance suggested here.

In contrast, Graham referred to a lack of power that he felt on one occasion with a client, evoking another dimension of the client-therapist relationship. This can be interpreted as a sense of feeling worthless or disempowered when the therapy does not seem to be working. It also speaks of a struggle between wanting evidence of 'success', on the one hand, and believing in one's skills and respecting the therapy's pace on the other:

Here I am, an experienced therapist, been doing this for 20 years, can't help this guy… I'm not sure I felt quite so positive at the time because I wasn't getting much feedback from him and I was thinking "All I'm doing is containing this." This is what my supervisor said to me: "This is all about our egos. This is all about us as therapists wanting to be effective." Do you know what I mean? Wanting some kind of evidence and feedback that we're good at what we do. (Graham)

John also referred to this sense of ego in his interview, of a sort of insecurity, albeit in the different context of being prepared to let go of a particular modality, without the therapist's ego being damaged: *'I think, bluntly, there's perhaps a more ego-threatening thing and that is to ask ourselves a question about why it is we feel so upset when we think our model is being threatened.'*

These perspectives underline the primary power base from which, arguably, subsequent tussles about modality appropriateness might have emerged. It echoes the humility Karen conveys in her co-creative approach to therapy with her clients and, along with Graham's supervisor's words and reflected in John's comment, evokes the implicit power in letting the ego go. As Graham comments, it is about simply giving it *'our best shot'* instead of having a strong investment of ego in achieving *'success'* through a particular approach to therapy.

These attitudes and associated images such as the didactic headmaster described by John (and which links well with John's view of existential revelation as a tool for exerting power and influence as a therapist).

The earlier cited references to *'dogma'* and the figures of authority that establish it – referred to interestingly, via the word '*guru'*, which again has *'cultish'* associations - evoke the sense of an egoistic influence on the selection of therapeutic modalities. This is arguably an uncomfortable implication given that the application of these modalities is, at its heart, intended to selflessly or altruistically benefit people. In this context, the specific characteristics of CBT and ET respectively become less relevant than the overall

rigidity of the canon of thought positing them against one another, and people setting themselves up as authorities in a particular approach, thus ultimately guarding against their ongoing adaptation and evolution. The power struggle here is clearly between rigid and more fluid applications of each modality. The sense of an ego-based investment in one approach over another, and the struggle to escape from that in order to embrace the evolution of a particular approach, seem to be a way of personally experiencing this struggle. This transpired through key words used by the interviewees such as '*admitting'*, which is used in Ann's quote below in the context of capitulating to the *'other'* side, which reiterates the notion of *'us'* and '*them'* in therapeutic ideologies.

> *I suppose people get very into the idea that there is only one way, and I completely think that of existentialism as well as CBT - that there is only this way and to open yourself to other ideas or other ways of looking at things is a bad thing, like you lose something… it's like the therapist or the schools think that they lose something in that in admitting that there are other good things, and we can kind of use parts of other good things.* (Ann)

6.2.5 The wounded therapist

The final sub-theme is defined as "wounds" in recognition of the therapists' own suffering relating to the type of therapy, often reflecting the suffering of their clients, and their inability to overcome it. The rationale for the use of the term "wound" to explain the participants' diverse feelings about CBT and ET is based on the identified linkages between the therapists' own descriptions of self-analysis, their personal transformations, and the seminal article, 'Wounded Healers' (Maeder, 1989). The latter has been extensively used in psychotherapeutic training to illustrate the importance for therapists

of self-reflection and understanding past wounds, so that they do not unconsciously impact upon the psychotherapeutic relationship.

Throughout many of the interviews, the participants highlighted negative aspects of CBT and conveyed the sense that these were deeply upsetting to them in various ways. These were generally associated with "pure" CBT, which most of the participants indicated as being at odds with their sense of subjectivity and perceptions of themselves and humanity. Illustrating this, CBT was described at various points in the interviews as '*cold'*, an '*angry headmaster', 'excluding', 'cruel', 'abusive', 'painful', 'exposing', 'disastrous', 'mechanistic', 'dangerous and traumatising', 'rigid',* and *'stressful'*.

> *I've had some very difficult work with people who've been traumatised by their so-called treatment…I think it's* [exposure therapy] *quite a cruel approach and can be quite abusive.* (Mark)

With these interviewees, the *"felt-sense"* of the application of CBT in relation to clients is clearly stated via the repeated diction of terms such as *"abusive", "dangerous", "cruel",* and *"goes wrong",* conveying these respondents' critique about the potential trauma and pain associated with the process of CBT. These types of views were expressed by practitioners at varying stages and levels of expertise in their careers, and can be summarised in the way that an overly *"mechanistic"*, surface-level approach to CBT could neither fully evaluate what the client was experiencing nor provide the therapist with the opportunity to do so, thus stunting them as a *"healer"*.

> *What that [CBT's medical model] does is it forces people into these nomothetic categories and applies techniques, in many cases, blindly to that. I have a huge sense of frustration with that.* (John)

In particular, CBT's rootedness in the rational and logical approach to individuals and their psychological suffering was often seen as preventing therapists from truly reaching the heart of a client's woundedness. Karen, for example, recounted having patients come to her after seeing another CBT therapist and commenting *"I could tell I was just a number".* Likewise, Ann commented*, "the experience (of CBT) is linked very much into the categorisation of people",* making the ideal CBT practitioner, according to her, a *'business person'* before they are a healer - organised, didactic, very questioning, and fearless, as well as good at navigating the new political landscape within which CBT is now situated. Stuart noted in this context:

> *I went to a conference in Oxford last year …. A number of (lectures) were about the theme of we have to make CBT easier for people because it's no good if we present them with a model that is so painful they can't use it. I thought that makes sense.* (Stuart)

In explaining why CBT can be wounding for the client and the therapist, John referred to the Rogerian concept that *'the client is the expert in their internal world'.* He admitted a sense of unease when observing the work of *'psychiatric colleagues'* adhering to a primarily positivist, medical model of CBT. In his view, this approach is unable to acknowledge and validate clients' claims to their own distress, and they (and by extension, the therapist), would remain wounded. In a similar way, Ann talked about some of the painful effects of CBT on the therapist as well as the client:

> *To have clients, three or four clients in a row for CBT, I mean, you'll have headaches after mainly because of the intensity, so much. So I kind of feel that if I feel like this, their head must be melted, that the intensity is an awful lot for people to say*. (Ann)

Despite these commonalities in many of the interview cases relating to the wounds of CBT, there were also instances where interviewees highlighted the benefits of this approach and the safe space it can provide for clients. For example, Stuart observed that CBT was increasingly moving into a more nurturing direction where clients were concerned:

> *CBT is adopting and moving into things like compassionate mind and imagery work, mindfulness, which are quite a long way from CBT as Beck originally thought about it. I think it is anyway, but very human, very helpful, very warm and compassionate.* (Stuart)

Similarly, Ann used what one might understand to be *'caring'* language in describing CBT, in highlighting the fact that CBT's typical outcomes can be *'comforting'* and *'safe'* for the therapist:

I think with CBT, you are comforted by the fact that if you follow this way of working that you are safe as a therapist or you are a good therapist, and I think that's kind of what we all deal with. (Ann).

However, the word *'safe'* as associated with CBT was also used with respect to another source of pain for interviewees – the perceived dominance within the NHS of a narrow and mechanistic model of CBT (the IAPT framework). That is, CBT's mechanistic character could make it simultaneously cruel and safe; these were the two contrary implications of the same attribute:

It's become mechanistic, it's become very much issue-focused as opposed to client focused… and I think the worst thing that's happened to CBT is that it's got linked in far too closely with politics and the NHS… (Mark)

As the NICE funding, if you like, is based upon measurable outcomes, that is why they felt they could only recommend CBT and EMDR … "How do you quantify the psychodynamic approach? You can't." At least, that's what they say. I guess that's another reason why, if you like, it is organisationally seen as a much safer approach. (Graham)

In contrast, ET was generally viewed by the participants as being, even if the outcomes were more difficult to quantify, sometimes more appropriate to understanding the subjective aspects of a client's distress from the client's own perspective. Despite this, a "wound" of ET was also identified by some respondents, relating to the way this form of therapy potentially created a sense of insecurity for the therapist in comparison with the

comforting *'manualised'* approach of CBT. Ann, for example, expressed this in terms of the lack of fixed techniques in ET:

> *I never actually know whether I'm doing it right. I couldn't say whether my technique is the same as your technique is the same as anyone else's technique, and I couldn't actually say what I'm doing that makes me existential.* (Ann)

In a slightly different way, Graham identifies the way in which ET can induce a fear in the therapist of asking difficult questions, such as those relating to death, an area which was pertinent to his own area of work with terminally ill patients, but which he envisaged as also troubling other therapists. Interestingly, his comment suggested the possibility that when suffering from this "wound" of fear, therapists might unintentionally project their own fear onto the client and thus also "wound" them:

> *We all have this huge anxiety ourselves about saying to the client "What is it about death that so frightens you? What is it about dying that scares you? Have you had any thoughts about what happens when you die?" We're reluctant to say those things because we are fearful of what response we are going to get from patients or from clients.* (Graham)

While ET is generally viewed as a more *'humanist'* approach, some respondents also seemed to associate it with loneliness and marginalisation, either because of limited acceptance of this approach within the therapist community or because of the way in which it is perceived to be excluded by the government in the NHS/IAPT initiative. Robert explained, for example, that absorbing ET into his work had initially been an

isolating experience. He had felt that no-one understood it or accepted it in his field, even though it became more accepted over time. His use of the term *'coming out'* is interesting in the way it denotes an association in Robert's mind with the revelation of another type of identity that may be seen as potentially subversive in a context where it may initially be rejected (i.e. being gay):

> *I kept very quiet about my existentialism for that very reason but eventually I came out… when I first started I fed it in surreptitiously and craftily but because the climate has changed I feel now it is much more accepted.* (Robert)

This powerful reference to *'coming out'* was resonant of several other respondents' initial reported discomfort of integrating existential approaches into their work. For example, Joanne also commented on the *'taboo'* aspect of raising certain key questions that have an existential edge to them, notably those relating to spirituality:

> *I think it is one of these taboo sort of subjects still because it's like … well, if we ask about that I won't know what to do with it …. These are big questions… we talk about people's sex life, all sorts of intimate things, but we don't ask them if they believe in God or have the faith or that sort of thing. And… that's such a big part of people's lives.* (Joanne)

These forms of tension can themselves be regarded as creating a wound and form a crisis of self-confidence for the therapist or healer. Conversely, some participants indicated that their own identity had in many ways been bolstered by their engagement with the ET approaches, highlighting the ways in which this approach can provide a *"salve"* for

potential wounds experienced by the therapist. Rather than feeling afraid and limited through taboo questions, Ann felt more comfortable, open, acceptant, and herself when using ET. She explained this in terms of her recognition over time that ET was part of her own personal outlook on life and how this in turn influenced her practice:

> *As I got a bit older and understood a little bit more, I then realised how I myself use it [existentialism] for myself in my everyday life … I mean, part of it is the openness of it, the individuality, like looking at people from their experiences and not making preconceived notions about who they are, who I am when I'm with them or who they are in different context … So, I like the way it's more about me as a person in the room, that existentialist ideal rather than maybe a type of therapy and I think then you can incorporate that within different types of therapies.* (Ann)

This sub-theme has highlighted the largely ambivalent attitudes of the participants towards CBT and ET, which within the umbrella of the super-ordinate theme "assertion of the human" have been interpreted in terms of "wounds". Overall, the participants expressed some criticism of CBT, highlighting for example their view of "cruel" and "inflexible" aspects of this therapy in its pure form and the ways in which it creates wounds for the client and therapist alike. On the other hand, several emphasised the perceived value and comfort, from the therapist's perspective, of the well-defined, structured nature of CBT, and contrasted this with the uncertainty and even fear that they sometimes experienced with the unstructured and open existential approach. Yet, ET was not necessarily insecurity-inducing. By being more person-centred, it could help both clients and therapists to fully express themselves. These perceptions and views about

CBT and ET provide important insights into any rationale for integrating the two forms of therapy from the perspectives of these interviewees, as discussed later in the chapter.

6.2.6 Assertion of the Human: Concluding Thoughts

The value of each approach was often discussed in terms of superficiality vs depth, structure vs fluidity, and power dynamics. CBT was sometimes, but not always, associated with superficiality, structure, and stronger power dynamics, whereas ET was often but not necessarily associated with depth, fluidity, and greater power balance. On the whole, the majority of interviewees considered that no approach was perfect for every client, for every therapeutic moment, or for every therapist – even though gurus and perhaps beginners tended to focus exclusively upon one or the other. Certain client attitdes were regarded as predisposing them more to one approach or another, which may or may not be compounded by an underlying presentation. Nevertheless, there was also no agreement on the relevance of particular modalities to particular presentations. Each interviewee had their own way of approaching this, taking a very different view of different presentations and how these presentations were manifested (namely via intuition, experience, modalities, life experience, and many more).

The integration of both approaches was not always regarded as easy or possible. Yet, combined, these experiences lend themselves to contrasting formulations of how CBT and ET modalities may co-exist. The following section deconstructs this potential co-existence by considering the position of existential thought in CBT and, specifically, its absence thereof.

6.3 Missing Elements

The interviewees often conveyed ET as an idea mainly contrasting to, and occasionally complementary with, the basic grounding of CBT. Significantly, it was also often positioned as the '*missing link'*, so to speak, between CBT and the probing of deep human challenges around meaning and identity - a link that was often perceived as crucial in situations of great crisis in a client's life.

As highlighted in the previous section, many of the interviewees seemed to regard as missing from CBT the ability to truly probe *'human'* issues with a lived experience approach. CBT offers the client an ability to understand aspects or concepts more intellectually than emotionally and creates a separation between the overall context of the client's life and a full experience. The perception of ET as something that *'stands in'* for this gap in CBT was reflected in the language used in association with ET, such as: *"at the core of people", "a way of life", "authenticity", "understanding", "essentialism", "context", "identity", "relationships" and "self-discove*ry". Conversely, a missing element to ET was occasionally mentioned by interviewees, as discussed in section 2.2.5, in terms of CBT-like practices, a perspective which demonstrated the perceived potential for adding value to the therapeutic context by integrating the two approaches. The following sub-ordinate themes elaborate further on these issues, with the first four sub-sections presenting the findings relating to "gaps" identified by the participants in relation to CBT, and the subsequent section discussing the gaps identified in relation to ET.

6.3.1 Theoretical and practical gaps

A number of the interviewees referred specifically to theoretical or practical gaps in CBT that they indicated ET might help to fill. Among others, John highlighted the missing element in CBT by contrasting Beck's original CBT approach with what he perceived to

be based on existential ideas. He explained that having originally been trained in a Rogerian tradition, he struggled to come to terms with the inferential approach of Beck:

> *One of the main goals for psychological therapy for me is to get clients to reach the so what position. So other people don't like you and disapprove of you. So what? What relevance does that make to your experience of yourself and your experience of the world? Seeing that … inferential stuff within a cognitive model I began to find very frustrating because actually the origin of why they might infer a certain something about the world was never open for exploration.* (John)

John's Rogerian theoretical foundations and, by implication, humanist-orientated initiation into the world of therapy and CBT's *'inferential level'* he struggled with underlines that the missing element was, for him was a theoretical one. In particular, the lack of deeper exploration into what lay beneath clients' inferences about the world, which John deemed crucial to really understanding their worldview, was not theoretically envisaged or allowed by the CBT model he adopted.

In contrast, Stuart's consideration of the potential gaps in CBT appeared to be more focused on its practical application level. He expressed that there was a tendency for practitioners using CBT to integrate other approaches to fill practical gaps and thereby improve the effectiveness of this approach, but without formally acknowledging the source of the appropriation.

> *CBT does have this sort of tendency, so if it finds something that works it just takes it, tweaks it a bit to put in cognitive element and calls it CBT, and CBT is adopting*

> *and moving into things like compassionate mind and imagery work, mindfulness, which are quite a long way from CBT as Beck originally thought about it… It's easier to ask the question the other way round: what has CBT received from the existential approach? What of the existential approach is missing from CBT?* (Stuart)

Despite the different emphases, both Stuart's and John's quotes suggested there was a need for a theoretical or practical bridge to be formed between CBT and ET in order for them to be understood as potentially complementary to begin with, rather than the understanding emerging through frustration in practice, or by CBT subsuming aspects of ET in a reactive, *'tweaking'* manner.

It is interesting to note that most of the interviewees did not talk about philosophical existentialism, although some do have a grasp on that, as demonstrated by Robert's reference to his initial university education in philosophy:

> *I think philosophy in general has a heck of a lot to say and existentialism in particular, of course… It's probably more fundamental for me as a framework than anything else, probably because I came across it long before I even went into psychology and I was so taken with it. (Robert)*

This comment reiterates the significance of a basic theoretical *'framework'* in subsequently shaping understandings of ET and, by extension, CBT alike. This lays the *'fundamental'* understanding initially embedded in the therapists' mind, from which subsequent theories and approaches can develop as they learn and train. It suggests the

importance of having a theoretical basis from the beginning of the learning process in CBT (or indeed ET) that may subsequently embed their thinking, philosophy, practice, and work as a bridge between approaches.

Among other interviewees, it became apparent that the ways in which existential ideas were understood and discussed had only a broad or almost non-existent connection with the canonical theory of ET. For some, the term ET appeared to be used mainly as shorthand for the '*missing human element',* as they experience it, in CBT:

> *I haven't trained in existential therapy and you know you pick up bits here and there and from different people. So I wouldn't say I'm very knowledgeable in terms of the existential approach as a whole. So I suppose it's just more from my own interest… I suppose it [existentialism] is those bigger questions of sort of why are you here, what do you think your purpose in life is.* (Joanne)

> *… [existentialism is] Just to help them to connect with someone, because that's what people want, connection… they don't want judgement*. (Karen)

These remarks suggest that there is a need for clarifying the theoretical foundations of ET, not because they explicitly stated so, but because they showed a gap. Crucially, as Ann commented, ET as a therapeutic approach had not been systematised as such and this had influenced the way in which it was often adopted by therapists:

> *To integrate it very well, you have to be very good individually at the two. That's what I would think and I don't think people doing a little bit of CBT as an*

existentialist is actually enough. I think that it ends up being watered-down therapy or better off sticking in what you're good at so you end up being a good existentialist or a good CBT therapist, but I think to be good at both you need a good bit of training in both for either types of therapies to be able to understand what's similar and what's different. (Ann)

This again points to the experience of a missing theoretical bridge between ET and CBT, and the need for this bridge to be constructed early on in therapists' training, in order for their attempts at an integrated to practice not be '*watered down'*.

A complicating factor here, of course, is the way in which the interview questions themselves were designed to elicit the factors around the integration of CBT and ET, whereas the interviews demonstrated that, in fact, integration means something much broader to the respondents. This will be elaborated in the second super-ordinate theme. Notwithstanding this epistemological issue, the discussions here show that in the process of CBT's evolution, existential ideas may have been adopted and therapists' may broadly understand and seek to incorporate them. Although not comprehensive, a theoretically bridging foundation is yet to be developed between the two.

The following section moves from theory to practice, highlighting participants' experiences with some of the specific ways in which they believe existential thinking might help fill some of the gaps within CBT in real life therapy situations.

6.3.2 The "human" gap

A key factor seen to be missing in CBT was the inability to adequately consider the client's emotional perspective - their feelings about a given situation and themselves, given CBT's emphasis on a logical, linear sequential way of unravelling their inner conflict.

Karen emphasises this by juxtaposing CBT's '*logical point of view, rational point of view,'* of a client's problem, with the client's own sense of helplessness when dealing with their irrational, emotional experiences. Such inner, emotive and irrational aspects were viewed as inevitably overriding their attempts to deal with their emotions in the logical manner that is offered by CBT.

> *I've worked with lots of people who've had posttraumatic stress disorder who've been able to understand what's happening to them and get their head round it from a logical point of view, rational point of view. But when it comes to the emotional reaction, they know it's irrational, but they cannot do anything about it. That's what CBT can't work on that deep level, which has sometimes come from childhood.* (Karen)

Graham also emphasises the logical structure of CBT and its limitations when dealing with clients that have a need to deal with more emotional and irrational experiences. However, the way in which he describes the limitations arising from this indicates that these gaps may be filled by a modified version of CBT - not by necessarily incorporating an existential approach.

> *I always saw CBT as being a very logic-based approach and it works very well, I find, with clients who have a practical turn of mind, want solutions and like to understand a process, so this whole idea of the A, B, C model: "What's the*

activating event? What are your thoughts and feelings about the event? What can we do about it?" Very straightforward, lots of clients like that, used it a lot – in shorthand – but the bit that seemed to be missing was that in the B phase – thoughts and feelings about the event – we're not dealing with the illogical emotions, so I thought that's how we could improve it. If we could expand – if you like – the B of the A, B, C model to cover these thoughts and feelings which don't make any sense at all, but are genuinely experienced and held, then I had a feeling that would enhance the practice so that's the bit I thought was missing. (Graham)

On his part, Stuart describes this "human gap" in CBT in terms of its inability to deal with the complexity of human nature. He likens this missing component in a scientific therapy to art:

So it's a bit like saying "What's missing? What of art is missing in science?" Well, all of it. [Laughs] Art is missing. I find very that difficult… a human being isn't science necessarily. They've got all their other things. Nobody fits into a category… It [existentialism] brings a bit more of a human approach to CBT because I found that with my own clients who've had pure CBT they complained they missed out so much. (Stuart)

Other interviewees in their references to client differences and idiosyncrasies also evoked the hard to categorise 'art' of being a human being. In particular, Ann discussed the issue of *'difference'* as a way of understanding what may be missing from CBT, contrasting this with how '*difference*' is treated by ET (or, more accurately, phenomenology). In this

sense, space for contextualisation and idiosyncrasy may be seen as a major element missing from CBT:

> *Part of it is the openness of it, the individuality, like looking at people from their experiences and not making preconceived notions about who they are, who I am when I'm with them or who they are in different contex*ts. (Ann)

Mark expressed a perceived '*human*' gap in CBT in terms of its aim of *'fixing'* people and, therefore, presuming that human beings' worlds can be controlled by some technique or train of thought:

> *One of the most significant existential philosophical things that I find missing from CBT is that there is an assumption within CBT that there is something to be fixed. Now, existentialism doesn't hold these assumptions in my understanding of it… I think a significant proportion of anybody's client list will have these sorts of clients where the issue is something that cannot be fixed - it's not going to be fixed, either because it's really just sort of too hardwired, like a sort of personality disorder, or it's a terminal illness, or it's a bereavement, or it's something which is totally out of anyone's control and therefore they don't have any choice about it. There's no point working on choices when [laughingly] there is no choice.* (Mark)

What is missing from the core CBT assumption that a *'fix'* is possible is deep attention to the individual context, presentation, and mentality of each individual. Mark's use of listing language to emphasise this - going through the different circumstances within which something is not '*fixable'* - conveys a sense both of the relentlessness of the CBT

approach in trying to do just that (i.e. ploughing ahead regardless of obvious obstacles such as these). On the other hand, it highlights the futility of CBT's efforts to do this, given precisely the immutability of these obstacles. The key words and phrases underlining their perceived futility are *'totally out of control'*, '*don't have any choice',* and *'there's no point'*, all compounded by Mark's laughing, which injects a light mocking of the notion that control and choice can be established over and above the 'hardwired' obstacles.

As well as missing a '*human'* dimension (i.e. not taking into account illogical and complex thoughts and feelings), contextualisation of individual circumstance and idiosyncrasy, and the freedom to let go of forced solutions to immutable problems, CBT was also seen as missing an awareness of the significance of authenticity to one's self and to others.

6.3.3 The "authenticity" gap

Based on the interviews, Authenticity is conceptualised as the ability of the therapist and their clients to openly explore the view that people have of themselves and others over the course of therapy. A perceived authenticity gap associated with CBT was revealed in the data based on several factors. These consisted of an apparent lack of self-understanding on the therapist's behalf; a lack of primacy placed on the client's own uniqueness and complexity, and a subsequent lack of empathy and rapport emerging from that; with a resulting lack of scope for both the client and practitioner to be grounded in their "authentic" or true selves.

Authenticity of the client situation: Mark explained the authenticity gap, for example, in terms of the ways in which CBT had evolved away from recognising the importance of a holistic view of the client, which takes into account the whole self as context and allows it to grow and change:

> *The earlier approach of CBT was that it was more of a holistic approach in the sense that it was more aligned to perhaps the existentialist idea of somebody becoming something or it allowed for general change in a client as opposed to specific changes and I think that was much more of a psychotherapeutic approach but it is now, in many cases, lost…* (Mark)

Mark's comment below clearly highlights the importance of not only recognising a client's uniqueness, but also appreciating it, and letting it be what it is:

> *You really have to go into context, into what's influencing the context… I have rarely met greater imaginative creativity than I've found in OCD people justifying their rituals. I think it's wonderful. I tell them that: "I think this is absolutely wonderful. Do tell me how you can then justify doing that and let's see just how creative and imaginative you can be."… I've never thought of it as existential but I suppose what I do is say "Okay, your problem exists." [laughs]… The problem exists in its own right; it's how you deal with it… and that is, in a way, one of the, how can I say, compared with pure CBT, that's the thing that pure 'CBT-ers' don't get.* (Mark)

Again, his laughter and sense of being relaxed in the moment with the client as they discuss their OCD underscored this. In addition, the use of diction such as *'imaginative*

creativity' reinforced the value Mark attached to uniqueness which, as it appeared to him during the interview, came through more strongly via an ET rather than a CBT approach.

Joanne also discussed at length the importance of acknowledging individuality and uniqueness within the therapeutic environment:

> *You're working with individuals and I think that's the thing with CBT - there's a danger of a model to fit all, you know. Rather than each person is unique, and I suppose it's based on my own personal values and belief that everybody is valuable, unique, has a unique gift to give to the world. And part of our journey is discovering who we are as an individual and our uniqueness and therefore value.* (Joanne)

By discussing the importance of bringing to light the value each person could bring "to the world", she seemed to further emphasise how the individual's uniqueness should be considered from within wider social, economic, and cultural backgrounds. From this perspective, the uniqueness of the client is inevitably mitigated and moulded by the types of structural factors that deep existential questions around '*the meaning of life*,' as Joanne defined it, on their own, do not tend to address. CBT, with its propensity towards the *'systemic',* might encompass these aspects. Yet, from Joanne's viewpoint, CBT also had the tendency to obliterate individual uniqueness – and therefore seemed to be envisaged as failing to consider them. As a result, and in order to capture the complexity of human experience, Joanne acknowledged that there was potential value , in combining modalities:

I was quite interested in systemic and CBT and in combining those two … I'm also interested in like cultural influences, environmental influences, eco-therapy all sorts of different things, you know you can't work with a person in isolation cause we don't live in isolation. (Joanne)

Authenticity of the therapist: The equilibrium that Joanne proposed as the optimum way of treating clients as unique individuals, and importantly her recognition of the role that her own *'personal values'* played in her approach to therapy also pointed towards the need to consider the degree of awareness of the uniqueness a therapist brings to a client and into therapy. Such awareness allows the emergence of empathy and rapport or relationship that they are able to establish with their clients.

Mark was also vocal about this point, emphasising that the key to understanding a client's '*true*' nature, their unique problems, and which therapeutic modality to apply to them and how, was to first undergo the therapeutic process oneself, as a practitioner, and not simply because this was a training requisite:

You start off with yourself. You have to have a pretty good understanding of yourself. If there are areas of uncertainty then, yes, it is appropriate to go for personal counselling until you get an understanding of yourself and then, on top of that, you have to have an understanding of yourself in relation to other people, so you have to work on relationships, and if you can't form a relationship or if you can't illustrate that you're able to form a good relationship and sustain a mutually helpful relationship, then you don't go any further … Only when you've got all of that do you start sort of deciding which techniques and which tools are

going to be the best tools for you to apply these understandings and these skills. (Mark)

The vehemence of Mark's views is demonstrated in his use of the imperative in framing his statements. It is also interesting that he prioritised self-awareness and relationship-forming abilities over the actual technical skills or qualifications needed to employ certain therapeutic tools. This injects a hierarchical dimension into his mind map of options and choices for the would-be therapist, in which the top level of self-awareness must be achieved first. After that, the therapist must work downwards in locating the correct tools to use with a given individual. Similarly, Robert emphasised this point, but equated it more directly with the existentialist approach to which he adheres:

You've got to do it yourself and to experience it, and not use it like a technique which you just apply. Existentialism is like that par excellence. It's a way of life. It's my way of life. It's my philosophy of life. (Robert)

This was a clear assertion of Robert's own uniqueness which informed his therapeutic approach, and helped to ensure that it is a rich and meaningful process rather than just *"a technique."* This echoed Mark's more general statement that one's own self-awareness and mindfulness as a practitioner should precede any kind of modality that is ultimately employed.

In this view, Robert argued that an existential approach could fill a key gap within CBT in terms of authenticity - not only for the therapist who had personally undergone the

experience - but also for the client by allowing them to explore the deeper meanings with regards to their genuine self. As he recounts of one client:

> *I was encouraging her to construct her authentic self more, and she was terrified of doing that. She did it bit by bit, and actually by the time she left seeing me she was doing quite well… She was building this up and dealing with her anxiety about that and now, of course, it was her genuine self, or enough of her genuine self to sustain it.* (Robert)

Here, Robert identified the goal of this intervention as *'encouraging her'* to create a self or identity that appears to fit her desired view of herself but it required her to confront her anxiety. It was unclear what this anxiety was, but experiencing this feeling of anxiety appeared to be an important part of therapy to Robert. Robert appeared to be describing an approach to therapy that CBT had missed: an awareness of the importance of authenticity in life (Heidegger's concept) and how living life authentically can be of importance to some people.

Robert also highlighted that the therapist's recognition of a client's uniqueness through empathy can powerfully help to bridge the gaps that may exist with employing a particular therapy. For example, he went on to discuss how his verbally expressed empathy with clients' own existential - '*mad*' – viewpoints, alongside the sharing of their experience, generated the important rapport needed to truly reach them:

I see some clients sometimes and they think it's part of their madness, [laughs] looking at the world from the existential point of view. I think sometimes they're absolutely overjoyed to discover not only that I really understood what they were thinking, that was the way I thought as well and that there's a whole body of philosophy of life, so it validated it … This, to me, is perhaps one of the most powerful ways of engaging a client, if it's possible to do so on that level. (Robert)

Robert's language of positivity and empowerment conveyed through phrases such as '*overjoyed' '*and '*powerful ways of engaging'*, did not focus on his existential approach itself but using the empathy and clients' sense of relief at being '*recognised',* so to speak, and validated as not *'mad'*. From this and also Mark's argument, it can be deduced that '*the genuineness and importance of rapport'* - and, crucially, the initial self-awareness that enabled it, might have been the missing link in situations where certain therapy modalities might not have the desired outcomes.

In discussing the potential shortcomings of CBT for certain clients and the flexibility required on the part of the therapist to adapt their approach thereafter, Karen referred both to the layering of skill and new knowledge while Mark signified on the importance of *'treating each person as unique*.'

I think if you treat each person as unique, it can be a real growing experience for yourself as a therapist. (…) [And] There's nothing wrong with saying, "I don't know." (Karen)

The fact that she equated this with a growing experience for the therapist as much as, presumably, a beneficial one for the client, suggested a symbiotic relationship between recognising uniqueness in clients and being skilled as a therapist, which will, in turn, boost that recognition further. It is within this symbiosis that the flexibility emerges and enables the therapist to seek out other approaches to fill in the gaps left by CBT. The humility that emerged in her latter sentence further emphasised the importance of the therapist being open and cooperative with the client in a mutual effort, i.e. building that vital rapport.

Perhaps, unsurprisingly, given the gaps that respondents have perceived in CBT so far, a key missing dimension was the one about grappling with the foundational existential questions of life, as the following sub-ordinate theme explores.

6.3.4 The 'meaning of life' gap

This sub-theme relates to a perceived gap in the ability of CBT to address issues that may be crucial to a client's ability to accept, engage with, and finally be at peace with core existential crises (such as their own impending death).

Graham, in recounting his long experience as a counsellor of terminally ill patients, illustrated the importance of bringing up existential questions and meaning – and also the pain engendered when they were neglected. He described the ways in which ET had allowed him to ask questions about the meaning of death:

> *So they would talk a lot about pain relief, putting people on a palliative care pathway in order to alleviate their pain at the moment of death … but nobody ever*

seemed to start that conversation: "Well, what do you think happens when you die?" It's almost like it's the last great taboo … We [Graham and a terminally ill patient] started with CBT. We then stopped that fairly quickly because he couldn't engage with the process. We then brought in some humanistic ideas to just kind of sit there and contain and hold it. We talked about why he was fearful of death and all of that, so that was where the existential bit came in. (Graham)

The juxtaposition of death being the *'last great taboo'* with death being part of *'humanistic ideas'* that 'sit there and contain and hold it', strongly brings forth the acceptance that is inherent to ET, versus CBT's ignoring and/or active fight against it, a remark which linked back to Mark's comment on CBT's insistence on fixing the *'un-fixable'*.

From Joanne's perspective the spiritual dimension was seen as reaching to the core of a person's meanings and values. Furthermore, she gave it importance in ascertaining whether those meanings are part of a psychosis or alternatively, an enduring aspect of the individual:

I think particularly if somebody is very religious that colours their whole life, whole way of thinking, everything. So to leave that at the door you aren't getting a full picture… over the last few years I suppose I've been making more of a conscious decision to look at… people's spirituality in terms of what gives them meaning, what gives them purpose if they have a faith, if they have a spiritual belief, how does that affect them and influence their way of thinking and whatever… if somebody has a faith that's totally ignored in the therapy it can be

a huge resource. Or it can, you know, be causing difficulties as well either way. So if it's not explored it's that sort of elephant in the room that can be a resource that's not being used, or can be undermining the therapy, or a bit of both. (Joanne)

Here, Joanne presented two different scenarios and sets of verbs associated with each scenario. Firstly, one in which spirituality is something inactive and ignored, '*the elephant in the room',* possibly causing difficulties and presenting an obstruction to the therapeutic process. Secondly, there is a vision of spirituality as an active participant in itself in the course of therapy because it is instrumental in affecting and influencing therapy. Its active exploration could help to detect and deal with the obstacles it creates and/or to transform it into a therapeutic ally - all active verbs denoted the usefulness of integrating this element into helping the flow and benefits of therapy. By implication, a stark gap within the possibilities of CBT in the context contained the 'inactive' verbs around spirituality.

Nevertheless, it is important to recall, again, that in discussing what was missing from CBT, specifically the existential components- several respondents also mentioned gaps they perceived to be missing within purely existential approaches. The final sub-ordinate theme illustrates this.

6.3.5 Key gaps in ET

The potential of integrating CBT and ET in therapy is also reflected in the finding that many participants identified gaps in ET that might be filled by CBT-like approaches.

It is worthy of note, however, that some of the comments about shortcomings in ET may reflect limitations in the understanding and knowledge about this approach and how to apply it, rather than weaknesses in the form of ET per se. For example, Stuart highlighted the difficulties and frustrations he had faced when attempting to apply ET, and attributed this to the lack of a rational structured framework or specific techniques to draw on:

> *Existentialism… is so esoteric. Also, existentialism lacks techniques… which is understandable. It's part of its ethos that actually techniques are man-made things. People's values. What would that be about? What are you trying to impose on the client with a particular technique? That's one of the things I found a bit frustrating about trying to practice it, that there wasn't enough of a framework. Perhaps with CBT there is too much of a framework, [laughingly] or there can be.* (Stuart)

The 'esoteric' nature of ET and its *'lack of techniques'*, in contrast to CBT, were seen as potentially alienating the therapist himself from the practice they were trying to enact. However, what also emerged from Stuart's words here was the need for a balance - while ET does not have enough of a framework, CBT has too much of it.

For Ann, ET was too self-referential and it echoed Stuart's comment about being too disconnected from technique and practice. She highlighted the difficulties of applying such an unstructured approach, especially for therapists working in the NHS in which the use of formal techniques is expected:

> *You're in an existentialist structure of psychology but you can't actually refer to any psychopathology… When you're probably going to work in an NHS job that needs you to know something about psychopathology, otherwise I don't feel you're giving your clients a good service if you don't actually know what a psychiatrist knows*. (Ann)

Here, Ann's perceived limitations of ET emerge in so far as it is conceived to be removed from "*actually"* knowing "*what a psychiatrist knows"*; the word "*actually"* undermined the legitimacy of ET to deliver what is expected of them in a structured clinical context. Therefore, it denoted a challenge of self-confidence and security for both the therapist and the client.

Ann also highlighted a perception that ET is a long-term approach which can be ineffective when dealing with particular issues such as depression, since clients may give up on the therapy if they do not feel that concrete results are being achieved:

> *I think with depression, existentialism, it takes a very long time, I find, from when I've worked purely existentialism it takes a very long time to move anything. I think then you can lose the person in a way.* (Ann)

Ann's association of ET with a sense of loss conceptualised this modality as an alienating rather than uniting force for both the therapist and client. This research participant expressed the view that, at least in certain situations, "*quicker fixes*" and "*less lengthy interventions*" might be more beneficial, though these are not defined specifically in the form of CBT.

6.3.6 Missing elements in CBT and ET: Concluding thoughts

In probing the super-ordinate theme about what respondents thought was missing from CBT (and, to a lesser extent, from ET approaches), an unexpected variety of responses were expressed. For example, these included emotional, irrational, artistic, spiritual, theoretical, technical, and practical elements. This range and complexity of responses can be interpreted as corresponding with the complexity of humans and their needs – including both, the therapists and their clients – and reflecting the perceived shortcomings of the two modalities in relation to these. Overall, it appeared that these therapists felt that CBT was '*inhuman'* in some ways, whereas ET or, rather, the way ET is conceptualised in a '*stand in'* sense, is viewed to be more effective in capturing the feelings of humanity.

These critiques of CBT and, to a lesser extent, ET, pointed to the notion that both approaches missed out on the full aspects of being a person, and suggest that there may be potential for integrating the two in a complementary sense. However, such a specific view point was not explicitly expressed by the research participants. The possibilities for this will be explored in the final section of this chapter which examines the specific ways in which the research participants have actually combined the two forms of therapy in their real-life practice.

6.4 Integration in practice

This section presents and discusses the research findings regarding the participants' actual experiences of integrating two therapies-CBT and ET, and highlights the specific approaches used. It also examines the ways in which the participants' personal and

professional backgrounds appeared to have shaped or influenced the ways in which different therapies were integrated in their practice. In order to do so, individual cases were analysed with an emphasis on the integrative journey of each interviewee from an experiential and interpretative perspective.

Employing this case-by-case approach does not, however, preclude bringing out relational themes. While each respondent's journey might be different, involving different intellectual levels, personal beliefs, and emotional backgrounds, they have all been led in different ways to the interpersonal nature of the therapeutic relationship (the understanding of which is also personal and particular to each case), and to the potential of integrating CBT and ET approaches.

Given the interpretivist nature of IPA, it follows that the presentation of data should flow from the nature of the data itself (Strauss & Corbin, 1990). In this particular study, the data called for a case study presentation of the therapist's specific journey towards integration. This type of approach was deemed appropriate because IPA permissively utilises both a case study presentation and thematic presentation. Additionally, as discussed in the methodology chapter, individual storytelling is a key aspect of interpretive approaches such as IPA (Creswell, 2013). It lends itself well to understanding the life trajectories of each of the respondents in turn towards integrated approaches - the *'main currency'* for an IPA study aiming to examine the particular experiences and meanings held by participants (Smith & Osborne, 2007, p. 53). Finally, IPA's necessity to remain flexible, exploratory, and descriptive as it seeks to present individuals' truths (Englander, 2012) also opens up scope for the presentation of these truths to adopt the

optimum form containing clarity and depth, which case-by-case narratives arguably achieve as much as a grouped analysis.

The purpose of this section will therefore be to present the data on how integration was constructed by individual therapists in this research. Three sub-themes emerged: firstly, the centrality of the background story and therapists' life experience and training; secondly, integration as unsystematised break out and 'feeling your way'; thirdly, the perceived importance of the therapeutic relationship as mediation for integration.

6.4.1 Personal and professional background

In my initial analysis of the research findings, I had not focused on the respondents' background stories, life, and training experiences. However, this theme lingered in my mind throughout the analysis, with key notes emerging relating to their extensive commentaries on training in different modalities, and also the issue of self-reflection. When thinking about the integration between CBT and ET and how different therapists constructed this integration, the issue of the self (themselves) arguably becomes central with regard to the participants' own intellectual and personal development and how they regard training, or the lack of it with reference to themselves and others. This section therefore discusses the findings on an individual level.

John: This participant showed significant amount of self-awareness as a psychologist and an applied philosopher. He mentioned that his key intellectual influencers were Rogers, Ellis, and REBT as he recounted having trained alongside an 'emergent' existentialist. He mentioned that the individuals influenced his initiation of his utilisation of ET. The comment below indicates that John had already purposely integrated ET into his practice:

> *I met someone who enjoyed and understood Being and Nothingness probably a damn sight more than I did in terms of understanding, but that was really quite influential as far as I was concerned, and also who I could have meaningful conversations to translate Sartre's work and sort of existential thinking into how I was with clients, which, interestingly, had probably been a part of how I'd been for a long time.* (John)

Here, it appears that John viewed intellectual development and engagement with new ideas as key in therapy, particularly enjoying the stimulation of *'meaningful conversations'* about existentialism and its relationship with therapeutic practice. It seems likely that his interest in new ideas and meaning are key factors that have informed his work and his integrative approach in practice, whether or not this was a conscious strategy on his part.

During his interview, John was critical of both CBT and ET training. He indicated that the training was often too narrow and it lacked inspiration. He made the point that, while education was essential, it needed to be grounded in a theoretical and philosophical tradition:

> *What is taught is just the technique as opposed to the philosophical root of that, which then means that what we have is blind application. I think that's highly dangerous actually… [on advice to therapists]… I fight with my temptation to want to say "Read a bloody book!" [laughs] I think the first thing is to actually ask fundamental questions of yourself about what is my basic principle for understanding how this works?* (John)

John offered this commentary in the context of what he understood by integration, which, in light of his words, can be seen as referring to an intellectual and philosophical understanding of the roots of different techniques before employing them.

Robert: This participant also reported a background of intellectual engagement with ET, alongside mindfulness, REBT, and other ideas. For example, ideals of Buddhism and those attributed to Chadwick and Rogers. He expressed the view that REBT was important because it allowed engagement with existential ideas by providing a vehicle for them. His engagement with ideas was presented as a continuous one, in which the self and the dynamic of self-development figured strongly: "*to me, it's like the process of self-construction is a continuous process right throughout life*".

Robert linked the perceived process that extended throughout life to his client relationships, conveying the sense that, for him, self-understanding and client work were fundamentally linked. This was highlighted in his account of temporarily retiring and needing to find a hobby as a way of mitigating the "*emptiness and loneliness*" left by the absence of client relationships, the vital platform on which he had previously formed at least part of his self-understanding (and, by implication, self-realisation). For Robert, the relevance of ET to clients seemed to be one of "*filling the whole*", which was also the way in which he appeared to view integration - i.e. as part and parcel of the therapist's own drive towards self-actualisation.

Therefore, both John and Robert regarded a core aspect of their approach to integration as stemming from their intellectual understanding, inspiration, and engagement with each therapy, its application and the possibility of integration.

Stuart: This participant differed slightly because his view leaned towards a therapeutic engagement approach to integration. He had undergone early training involving a psychodynamic and systemic paradigm, but, as he grew increasingly interested in individual work, he went on to read Yalom and formally studied ET. Later he started an NHS role and studied CBT and REBT. This mixed theoretical and technical approach resulted in a fairly organic process of learning about integrating approaches he most resonated with, as opposed to systematically and deliberately working through them, a process which will be explored in more depth in the second sub-theme.

Stuart referred directly to the importance of experience and the relevance of the therapist as a person:

> *It might just be a thing you bring that does make my hybrid approach work better. I don't know what I'm saying. I'm getting tangled up, because I suppose that's also a matter of experience, isn't it?* (Stuart)

This comment conveyed a slight sense of insecurity with regards to developing his *'hybrid'* approach through an organic process of self-development; however, as he continued, that very insecurity became a fundamental tenet of ET and a way of better accessing clients' own feelings:

> *These are basic things that are common to all humans. All humans have these basic concerns and do a bit of work on yourself so that you know what you think of them, how they affect you, how you've dealt with them in the past, what challenges they present to you and if you're aware of how you've approached*

those struggles you're much more likely to be able to introduce it into cognitive behavioural work. (Stuart)

Thus, for Stuart, engaging with existential concerns and struggles as a person can ultimately aid in integrating the existentialist perspective with CBT approaches for clients while working as a therapist. Here, integration lies in being aware and understanding one's self-development and their stance as a therapist in relation to working with clients.

Graham: This participant indicated that his experience of supervising medical professionals who were dealing with serious health conditions had made him aware of the need to bring in existential ideas about death. His formal training was fairly diverse, with humanistic, psychodynamic, and then CBT models being the main influences. ET entered his sphere of reference as a practitioner as a result of extensive reading and the impact of working with terminally ill clients. Therefore, to some degree, intellectual influences were important in informing Graham's approach towards integration but it was greatly driven by his therapeutic experiences and a keen interest for exploring the meaning of death in both personal and professional contexts:

When I first started reading Yalom and van Deurzen and all those others, it was a real light bulb moment for me, but that was a few years ago now and I remember thinking: "yes, I need to look at my life and decide what I'm doing with it," and did make some changes as a result, so it is quite profound. I think that once that light bulb has come on it does change what they [clients] do, so from that point of view I think it's very important and not just weaving it in with CBT. (Graham)

Here, Graham emphasised the importance of existentialist thought in motivating real, deep change at cognitive as well as behavioural levels. This outcome was further regarded as being unlikely brought about by simply forcing its integration with CBT approaches.

Mark: This participant was not a trained existential therapist but described his approach as phenomenological (i.e. getting to the *'essence'* of a client's problems and needs), with the key elements of acceptance and mindfulness. He made a clear distinction between earlier CBT approaches and contemporary expressions of it, and referred to his experience of reading Laing, which significantly informed the importance of context in understanding clients (e.g. by posing questions such as: is it the context or the person that is mad?). Mark elaborated his views on training, indicating the belief that personal development and self-reflection are a critical part of being a psychotherapist, but disagreed that personal therapy is necessary for all who choose pursue the therapy profession:

> *You cannot create an issue to go into therapy with and expect it to be the same sort of therapy… I take Roger's view that therapy is when somebody [the client], where there is an issue, is really concerned and incongruent with the issue, and somebody [the therapist] is quite congruent with the issue, and it's working out the difference that is the therapy. Now, if both are congruent with the issue and it's just a hypothetical sort of thing then there is no therapy; there can be no therapy.* (Mark)

These beliefs are likely to have influenced Mark's approach to integration, which for him, unlike John and Robert, is not mainly linked with intellectual development. Neither is it

a case, with him, of engaging with foundational meaning in one's life, and the trajectory through that meaning as an individual, as with Stuart and Graham. In considering integration, Mark's focus appeared to be more about the need for a pragmatic recognition of one's needs and limitations as a therapist without forcing any contrived self-introspection that may be unnecessary and achieve very little. His words did not directly point to CBT/ET integration *per se,* but it evoked the optimum context, in his view, in which there is a potential to develop new approaches.

Joanne: This participant similarly had undergone no formal training in ET, and her dialogue frequently indicated that she conceptualised ET as a stand in for spirituality. She worked with early psychosis, trauma, and suicide issues, which may be seen as both feeding into and emerging from her interests in spirituality and the transcendent:

> *I think over the last few years… I've been making more of a conscious decision to look at, I suppose the way I see it [existential issues in therapy] is more spirituality.* (Joanne)

Throughout Joanne's interview, she mentioned various specific influences on her approach to therapy, including mindfulness, CBT/REBT, IAPT, person centred counselling, and training as a clinical psychologist. Within this spectrum, spirituality, made synonymous with existential issues, is presented very much as 'creeping in', almost a private moment, because "*there's something that's sort of core of who you are*". The key theme that emerged here with respect to integration was that of identity and layering any other approaches on top of that. It appeared that, for Joanne, ET was something that lied at the core of identity in a transcendent sense, and was intrinsic to it (in contrast to the organic journeys and learned understanding that Stuart and Graham present). It then

followed that 'integration' is not so much integration *per se* but rather, an 'addition' - the addition of new modalities to an irreplaceable, immutable core.

Karen: This participant was a clinical psychologist and accredited CBT therapist who worked with Neuropsychological disorders and PTSD. While reporting that ET had been an influence on her approach to therapy, she also manifested a strong interest in integration with her neuroscience background. Having largely worked in the modalities of EMDR, memory networks (unprocessed memories), and acceptance and commitment therapy (ACT), Karen discussed how all contain particular sub-sets of models or techniques which are not rigid CBT derivatives and work effectively. Therefore, it can be argued that her view on integration was based on experience, similar to Stuart. Specifically, it is based on learning by doing - trying what works, negotiating and re-negotiating that with the client (as previously highlighted in her attitude towards the co-creation of therapy) and undertaking on-going formal and informal training. With regards to the latter, she commented that while training could be expensive, '*there is plenty on the Internet'*, emphasising the auto-didactic nature of integration in her case.

In different ways, Graham, Mark, Joanne, and Karen stood outside of formal attempts to integrate CBT / ET. They expressed a *'stand in'* view of ET and displayed fairly diverse and less systematised forms of integration.

Ann: She was the only participant who explicitly considered the similarities between ET and CBT, commenting extensively on the need for a thorough grounding in each before systematically integrating them. On a similar note, Ann was also strongly in favour of systematising and theoretically grounding therapeutic techniques. Ann exhibited how

both intellectual and personal experience influenced her practice and approach to integration.

Having obtained a degree in philosophy and psychology, she initially preferred and paid more attention to the latter, but over time reported developing more of an interest in philosophy, which appeared to have influenced her approach to integration:

> *As time went on, I actually realised how important … some of the ideas that I was actually using … with myself, and how I dealt with things in my own life, and from that I was very interested in the idea that every person as an individual, that we're all different, and I really took that aspect and kind of saw the strengths and what people, as individuals, can do rather than maybe using it for saying, well, all people of this category are this type … I'm still kind of in search of what it actually was about the philosophy that I liked. There were a lot of parts that I didn't like about it, and I suppose it was really in my study in a way that in round about way came back to the existential idea using kind of the phenomena with images, and that's how I came across, kind of, phenomenology.* (Ann)

For Ann, ET became part of self-development as well as a topic studied academically but one she struggled with when it came to translating into professional development in terms of finding something that could be used – 'phenomena with images' – which further translated into art therapy and child therapy.

Another important influence on Ann's life and potentially her work was the experience of childhood illness which she indicated resulted in the construction of self-identity as somehow "*different*". Though only a tentative interpretation can be made from this, it is

possible that it influenced her rejection of '*categorising*' people as mentioned in her comment. It may have also influenced Ann's sense that the different therapeutic modalities and ideas she could choose to use were "*more about me as a person"* again evoking the idea of identity as a key influence over what she does in the therapy room.

Ann also studied psychoanalysis, although no longer used it (she did not say why), and trained in CBT; overall, she did not feel that she was a *'pure existentialist'*. Ultimately, her notion of integration appeared to be one of congruence – she called it a '*marriage*', between what she had personally undergone in her life, and what she had professionally worked on or been trained in.

The analysis in this section demonstrates the respondents' diverse ways of understanding and undertaking integrative work, with some based on an organic process of learning and self-understanding, some on a more systematised, deliberate, and intellectual approach, and others still going from a point of perceived intrinsic identity values. Each way of thinking about and enacting integration seemed to have its own impact and corresponding influence on the client that was generally viewed as reasonably successful for them. It seems plausible to conclude that the ways of doing therapy arise due to significant life experiences, ideas, and training of the individual therapist.

The following sub-sections pull together the key findings of this case-by-case analysis into over-arching sub-themes.

6.4.2 The unsystematic nature of integration

Overall, what particularly stood out was the lack of one single, unified vision or model to express *'integration'*, which was also noted by certain respondents. For example, Ann

recounted her struggles with the absence of this model, with Robert echoing this by trying to find connections and congruence between the diverse theories. While some of the other respondents pointed to connections and implied (rather than explicitly stated) the lack of an overarching mode of integration, it did not seem to trouble them.

When respondents discussed integration, with reference to the collective themes in the previous sub-section, they further emphasised different aspects, such as how they arrived at integration and what integration was, for them, theoretically or in practice. Namely, integration was described: as a process of intellectual development (e.g. John); as personal revelation (e.g. Graham); as opposing but also connectable or complementary ideas (e.g. Ann); as a personal preference or style of therapy (e.g. Joanne); as fluidity and adopting new ideas (e.g. Stuart); as the importance of context, such as previous training (e.g. Mark); in terms of a holistic and creative approach (e.g. Karen). Given all the variations and nuances in the understanding of and arrival at integration, there emerged a sense of this being something that respondents 'broke into' following their own process of *'feeling their way'*; that is to say, there was often something unsystematic within their journeys towards thinking about, understanding, and using integrated CBT/ET approaches in their work. This section probes these unsystematic journeys, and the unsystematic nature of integration itself to which they have led. Given both the differences and similarities between respondents on issues of integration, their views are again presented as a case study format.

To begin with, John understood integration as both a point of intellectual connection between theories, therapeutic practice, and the clients and therapist's experience of the world. For example, he cited Rogers in highlighting the importance of trying to '*engage*

them at an early stage, I suppose, in the idea of actually being at the centre of their distress.' This seemed to be a function of substantial experience – a confidence perhaps attributed to John's active responsibility over the therapeutic role as opposed to relying on theoretical models. He confirmed this point when he says:

> *So you might have therapists from different modalities. Provided they're confident within their therapeutic and theoretical skin, the outcomes seem pretty much the same.* (John)

In John's case, therefore '*feeling his way'* was primarily a case of acquiring experience and confidence as a practitioner, as well as continuously learning and being comfortable with theoretical underpinnings. So, whilst John was 'angry' with CBT and the rigidity he perceived therein, in his own practice the philosophical and therapeutic utilisation of different modalities was already integrated given his longstanding experience and confidence.

For Robert, the integration of ET and particularly REBT was not so much the result of a sudden break through but had been reached in an evolutionary, organic way over time. Presently, they were so interconnected that he was unable to establish clear frontiers between the two:

> *I can't honestly say where REBT ends and existential begins. They're so integrated in my mind… I see REBT as the cognitive therapy that does integrate very well with the existential dimension…[of] CBT.* (Robert)

Robert also recounted that ET had long offered him a framework to '*guide*' him, even if he did not necessarily use it for particular clients. Interestingly, he was one of the few respondents to perceive direct similarities (rather than just complementarities) between ET and REBT, such as the concept of the self not being *'rateable'*:

> *To me, REBT [isn't] like other forms of CBT. For example, Ellis himself had read existentialism because he was greatly influenced by Paul Tillich's 'The Courage To Be'. He read that in about 1950 and it had a big influence on him. Certainly, the concept of self, when he said "the self is not rateable" is very similar to an existential view of the self. It was much easier using an REBT model to bring in existential ideas. (Robert)*

For Robert therefore, it can be interpreted that the systematisation of integration is irrelevant given the symbiosis he sees as naturally existing between the two approaches. Such perception seemed to further come about, at least partly, as a result of his theoretical knowledge of both approaches and their development.

Both John and Robert presented a strong intellectual notion of integration. Robert also demonstrated an interesting utilisation of Vygotsky's idea of the Zone of Proximal Development, which touches upon the practice of integration and the idea of being '*locked in'*. He argued that ET could serve a function in getting past being locked into a certain type of conceptual thinking, and how this was *'a real skill'*. Again, the ability to integrate and be flexible is seen as a function of experience (rather than intellect alone) - of feeling one's way towards that skill level.

Stuart, in a slightly different way, had also applied integrated ET and CBT in his practice. For him, it seemed like ET had made it impossible to practise a pure CBT model, as he was unable to extract the existential approach from his own mind and, therefore, from his practice. He and his '*CBT supervisor'* repeatedly referred to his approach as a *'hybrid'*. It involved a 'loose' or flexible utilisation of both CBT and ET. However, Stuart also expressed the view that integration and the failure to apply a "pure" approach to CBT or to ET could be seen as problematic in the learning and institutional context where he was located:

> *Maybe you can do CBT and existentialism, which is what I sort of try and do anyway… I tend to use the protocol a bit loosely and so I don't do CBT very effectively. It's not pure and that's why my supervisor raises' her eyebrows but if I had an existential therapist they'd be saying, why are you using this model? Why are you drawing this diagram?" So I wouldn't be pleasing them either… My CBT supervisor is dyed in the wool behavioural CBT.* (Stuart)

There are apparently several layers of struggle for Stuart as he feels his way towards integration. First, his more integrative approach is at odds with his supervisor's more conservative, '*dyed in the wool*' view of CBT. This appeared to create a sense of conflict that, in turn, engendered insecurity given the differential power positioning in the situation between him - the student - and his supervisor, who he referred to as a *"very intelligent, extremely well-practiced"* proponent of CBT.

An element of self-critique is also apparent in Stuart's acknowledgement that '*she despairs of me sometimes*' and in recalling her implied censorship of his existential ideas via her *"raised eyebrow*." However, his relaxed, laughing manner as he recounted this,

together with the 'accolade' he eventually received from her when she invited him to integrate his existential ideas into the CBT approach with some particular clients, introduced another, and final, layer - that of the breaking through, the being recognised and acknowledged for the legitimacy of the integrated approach proposed.

Thus, ultimately, integration in this context is sought and achieved via the re/negotiation of a power conflict, and by apparently reaching compromise on both sides - *'apparently'* because integration is what Stuart says: '*[I] sort of try and do anyway'* which evokes the '*default*' nature of integration, common to John, Robert, and Stuart, and also mirrors the approach used by Joanne as discussed earlier. Stuart explains:

> *I don't actually apply this hybrid approach because I think it would be better. I think I apply it because I think it's the only one I can do. I can't do it any other way but if I try to work purely existentially I seem to get involved in too much other stuff, and if I tried to do pure CBT I'm just too interested in other things, so does that make sense?* (Stuart)

So integration here springs from a sense of self and personhood of the therapist, with the '*hybrid*' approach being the only way that CBT and ET respectively make sense for Stuart in a professional environment. Stuart exhibited less of an intellectual approach to integration compared to John and Robert.

Graham mainly discussed integration through his cases by providing specific and lengthy details about each. The interesting thing about it was the lack of any explicit pattern to his approach or how he arrived at integration. The fact that Graham explained how he integrated CBT and ET through his cases is arguably illustrative of the client-tailored

approach he employed, one which is dictated by his experience/intuition and the levels of comfort and discomfort of his clients with each model. Graham did not show any hesitation in describing himself as "an integrative practitioner":

> *I was originally trained in the humanistic approach – Carl Rogers and all of that – and then I thought there was something missing so I went and got trained in psychodynamic, did a lot of work on that, which is particularly useful with patients' history, if that's something that's relevant. Finally, my third module, if you like, was CBT and I always saw CBT as being a very logic-based approach…[the existential approach influences him] quite a lot now because depending upon what the client brings – what that the story is [I choose an approach].*

In discussing his approach to integration, Graham indicated that the success of it is largely made possible by clients' own lack of familiarity with the modalities and their willingness to trust him and enable him to decide.

> *As a therapist, so far it's all been very positive. It's felt very comfortable for me doing it and certainly in the case of most clients who don't know the difference between one form of [laughingly] therapy and another anyway – they just do it – the response with most clients and patients has been good.*

Diction such as 'positive' and 'comfortable' that goes alongside 'useful' and 'relevant' reinforce his conviction in the validity of an unstructured integration but also one that revolves around client's needs. Later, he also talked about the need for deliberate

engagement and bravery in integrating CBT with ET: *Don't shy away from it, learn it, soak it up, and then have the courage to use it. It will make a huge difference.*

The expression - *'soak it up'* - seems reflective of having, over time and seemingly by learning, understood and internalised the validity of ET and integration. From this and the detailed individual client narratives he presented, it can be said that cumulative learning and the willingness to experiment and/or be flexible, are key to successful integration that makes *'a huge difference'*. Integration per se was regarded as utterly beneficial but it did not offer a very systematic nature. It was made possible, at least partly, due to experience.

In Mark's case, it is similarly difficult to identify his specific approach to integration other than to put forward through the description of cases. There was a sense of vagueness in his discussion of how in his practice he did not use any particular model. He referred simply to 'integration', without specifying what that meant but observed that the model used "*is more to do with the therapist than the client*". The approach to integration appeared to be less client-led when compared to Graham's, whose application of integration depended upon the therapist's understanding of the clients' needs or their context, and indeed to other participants who explicitly stated they were primarily client-led, such as Karen. The process of integration that Mark described was fundamentally about the therapist's own understanding and selection of appropriate tools. To précis and reiterate a comment included earlier in the chapter which best encapsulated his approach:

> *If you haven't got a shedload of different approaches or different tools you can pull out and work then it's rather like coming across a sort of really overgrown, gone to seed garden that's gone wild everywhere and you come with one tool …*

Your techniques, your approaches, need to be left in the shed until you've worked all that out. (Mark)

Mark's vivid imagery of a wild garden - a metaphor for the client's state of mind - that is not amenable to merely one tool evoked the image of the therapist as someone who needs to not only dig and work hard through the wildness but also who needs to understand the reason why the garden was in that condition in the first place. The organic nature of this image is then juxtaposed with the artificial *'techniques'* and '*approaches'* that need to be left in the '*shed*' until there's a full understanding of what lies beneath the soil. This suggests that the process is also for Mark partly client-led and that the journey towards integration - the '*feeling things out'* - is more significant than the actual mode of integration itself, as it was in this journey that integration (if indeed that is seen to be the most valid approach) was given its legitimacy.

There was also a distinct relational dimension in Mark's quote; i.e. the focus on observing and interacting closely with the client to first understand the problem and then apply the best approach. For Mark, the issues of integration and the therapeutic relationship were quite interrelated, an aspect that will be re-visited in the final section.

For Joanne, the issue of integration was presented as a complimentary one to her interest in spirituality and as a way of accessing meaning. However, she mentioned issues of context and referred to systemic theory:

> *Over the last few years I've been thinking more about and I suppose in my head I've sort of termed it holistic CBT. Just to sort of broaden it out and look at, you know, a person in context in terms of systems and systemic, but also in terms of spirituality and what's important to them and things like that.* (Joanne)

This quote arguably conveys a very clear systematising of integration, both in terms of the way it is compartmentalised in Joanne's mind - she had *'termed'* or clearly labelled it *'holistic CBT'* - and in terms of how this was arrived at, as she neatly listed the various criteria employed in broadening out her original foundation of CBT. Her version of integration thus seems to be constructed as more of a model in itself (i.e. a collection of ideas on how to view the person which influences therapy). For example, she was happy to use IAPT '*Value Cards'* as a way of discussing values with a client while maintaining openness to their spirituality. This is an interesting approach to combining what might be regarded as polar opposites – a systematic approach and an emphasis on spirituality – into a single cohesive paradigm. It represents a different view of integration to that of the other respondents discussed so far, one which could be regarded as being underpinned by potential contradiction and compartmentalisation rather than complementarity and/or addition.

It is also interesting that Joanne talked less explicitly about the therapeutic relationship, and more about being '*client-led',* though this seemed to presuppose a relationship in which the client had a greater degree of influence. The question that emerged from it was whether or not there may exist a relationship between being technique-orientated and less directly interested in the therapeutic relationship; this will be dealt with in detail in the following section.

Karen, in contrast, appeared to associate integration strongly with the importance of the therapeutic relationship:

> *I don't stick to a model. One day a client might come in and they might be feeling really down, and it might be something that they just want to talk about, do you know what I mean? So you can't, you know, you have to be responsive.* (Karen)

It can be argued that this responsiveness and orientation to the therapeutic relationship is less about the particular modalities utilised and more about the therapist herself actively deciding to '*feel her way*' towards what might make her client more resilient and capable of taking responsibility. Therefore, the relationship defined is more likely to be the key factor that enabled this therapist to reach and enact her own version of integration. Additionally, as highlighted in the previous section, Karen regards understanding and training in different models as being critical to successful integration.

Robert stressed the similarities and complementary nature of REBT and ET, corresponding Ann's emphasis on how ET and CBT were similar modalities, asserting that "*they are all born out of similar ideas with a different slant*". She gave the examples of both therapies involving a similar style of questioning the client and giving the client the freedom to choose different or new options. Ann viewed the ability to harness these similarities between approaches as useful in aiding a therapist's responsiveness:

> *I suppose seeing the similarities of the two approaches is a big thing, that realising that, I suppose that the two could be married together rather than maybe polar opposites, and I think if you come to terms with that and you're able to understand that it's not an clear cut type situation.* (Ann)

By referring to integration between the modalities as being a "*marriage*", Ann was using quite a strong metaphor which evoked a strong, emotive, and lasting bond. Her earlier statement that seeing the similarities is "*a big thing*" further emphasised the point. Therefore, in Ann's view, it seemed like integration was a significant undertaking not to be taken lightly, especially given the nuances that inevitably occur, such as the merging of the two (with neither being '*clear cut'* once they are integrated). Ann also argued that a thorough grounding in particular modalities is important before a therapist is able to effectively integrate them. Concretely, she explained how she had modified CBT in her practice with the use of *'metaphor', 'visual imagery',* and '*stories'* because these allowed clients to hold on to the ideas they had been exploring rather than *'lose'* them with semantic and analysis-based contentions alone, as with CBT. Here, it is also possible to observe how important the therapist's judgement was for the integration process and how each approach must be understood, combined sensibly and applied for enhanced effectiveness.

Like Stuart, Ann also referred to integrating ET as being more about who you are than a specific set of techniques:

> *I think it's actually a way of life rather than...I do think it's good in the therapy situation on its own but it is more about your way of life like how you live your life and… you can use that with anything because that's actually a philosophy of living.* (Ann)

Like John, Robert, and Stuart; Ann viewed integration as being a fundamental aspect of identity and driver from the beginning - '*a way of life'*. However, Ann differed from them in drawing out the implication of the therapist having this consistent awareness '*within*'. It was important for the therapist to understand and appreciate that this was a '*way of life'* so as to be consistent when working with their clients and not confront them unexpectedly with a new set of ideas.

Overall, it was interesting to find the research participants' different approaches to integration. Even though many of the interview questions were designed to explore the experiences of therapists in integrating various modalities (with the focus on CBT/ET), the participants were not able to answer these with absolute clarity. For those who adopted a relatively systematic approach to combining modalities, their related ideas and practices were explored.

Another key point that emerged was that integration between CBT and ET was not generally *"pure"*" but complicated by the different understandings of both CBT and ET and the tendency to add other modalities. This connected to a previous sub-theme - the belief that the use of any particular modality is often dependent on client presentation. It also connected with previous data about the '*stand-in*' understanding of particular modalities. The lack of *'pure'* CBT-ET integration among some respondents was

reflected in their expressed views that therapeutic work is or should be a work in progress with fluidity and the ability to incorporate new understandings. This aligned with the previous theme as respondents were wedded to theoretical and professional pragmatism (i.e. the appositive of totalising theory or models). It also aligned with the following theme that is agreed upon by most therapists, namely the almost *moral* centrality of the therapeutic relationship; in other words, an integration also *'stands in'* for something that is an attempt to summarise the '*mysterious'* aspects of psychotherapy, summarised as the relationships and bonds between therapist and client.

6.4.3 The therapeutic relationship (TR)

Many respondents placed considerable importance on being client-centred or client-led. Within this, there appeared to be an almost intuitive process of working out what the problem was. Many participants commented on the importance of the therapeutic relationship (TR) in their work. One of the aspects highlighted was the dynamics established between clients and therapists, wherein none alone has the lead as both are equally important and cooperating for a particular therapeutic event to come about. The importance of the relationship seemed to emerge when participants referred to how their interactions with clients were mutually constructed or influenced by both parties. It was almost the mystery at the core of what they do, and that which is most challenging for *'pure'* CBT. By referring to the therapeutic relationship in their conceptualisation of the integration of CBT and ET, respondents conveyed that the lack of systematisation was at the core of how they viewed/enacted integration and it was seen as the therapist's responsibility over the unknown aspects in the relationship. This section presents respondents' reasoning to that end, again on a case-by-case basis.

John remarked that the TR allowed clients to *'engage with their own distress*', and thereby enabled the optimum integration mechanism to be located:

> *Well, actually what I will ask people is: 'can we talk a bit about what it is you say to yourself about yourself in that situation and how you experience that?' Where is that me being an expert? It's about getting into that client and almost, as it were, accepting that I will have knowledge that can be useful in terms of where the client is. I will have a range of mechanisms by which I can encourage a client to reflect on their experience in a way that perhaps they haven't, and to confront some of that experience for them.* (John)

The '*range of mechanisms'* refers to John's integrated approach, which application is here very much seen to be led by the internal workings of a particular client's mind. In other words, the onus is on the TR - the cooperation between the client to open up their internal world and the proactivity of John to support such process and join them. Only then could the best therapeutic mechanisms be selected since there was no trace of *a priori* 'expertise' of the therapist. Later, John reiterated this when talking about the fact that "*you walk with the client in their own internal world. Woe betides you if you try and do it from outside. Well, at best it's going to be ineffectual for the client; at worst they're going to experience you as just a kind of dictatorial maniac,"* the latter phrase recalling his concern with CBT's 'angry headmaster' demeanour. What is evident from this quote is the need for balance between the TR and techniques used, envisioned as a balance between the *'inside'* - the client - and '*the outside'* - the therapist and their techniques which should never be imposed or override the internal but, rather, seek to be *'effectual'* or *'useful in terms of where the client is,*' as he noted above.

John also talked about therapeutic engagement in the context of dissatisfaction with Roger, which indicated how he conceptualises the TR:

> *I feel like this is a confessional now – that my original preparation was Rogerian and I struggled with some elements of that in that I struggled with what I saw at the time as a lack of structure. What I believed and I still struggle with now is a kind of abdication, at times, of therapeutic engagement with the client.* (John)

John put forward an idea of engagement which suggested that the proactive interaction of both client and therapist ("*It's about getting into that client and almost, as it were, accepting that I will have knowledge that can be useful in terms of where the client is").* Perhaps this was at the crux of John's drive towards 'integration' - an integration not so much of clear-cut CBT and ET as separate, but that of the CBT *'angry headmaster'* figure with the more exploratory and supportive ET therapist. This seemed to have implied his '*struggle*' with what he perceived as the '*abdication'* of the TR, suggesting the importance of the TR to him and by extension, the difficulty in integrating the two different modalities' therapist personas.

For Robert, it seemed to be the inclusion of ET that allowed for the possibility of a successful therapeutic relationship which conceptualised in terms of closeness, rapport, and engagement and reported as being a relatively rare occurrence:

> *With just a few I've had that experience, which has been wonderful and you get a sense of closeness then with your client, which is quite unique… I was thinking about Rogers' core conditions – the genuineness and the importance of rapport.*

> *This, to me, is perhaps one of the most powerful ways of engaging a client, if it's possible to do so on that level… I'm a great believer in the therapeutic bond, which obviously in all forms of therapy is essential. I was trying to say that being with me and the interaction and the experience of being with me, did that give her a sense of identity in herself, which was different from her mother's identity? She saw and realised that and so she could see this as a bridge, in a way; that it was possible for her to have this with other people.* (Robert)

Here, Robert positioned the TR as a '*therapeutic bond'* in relation to a client who had not experienced being with others as a positive emotion. In this context, broadly in Robert's practice, the TR was implicitly used to offer an alternative sense of self - a unique and original identity distinct from pre-imposed familial or other conditioned bonds via the connection and trust generated which Robert associated with a Rogerian approach. This could be seen as an interesting use of ET where it was the persona of the therapist himself who was harnessed to creating or being the '*bridge'* to bring the client over from one way of thinking to another. It was not completely clear where integration appeared within this. However, Robert's comment that the therapeutic bond is *'essential'* in all forms of therapy arguably attested to the necessary inclusion of this feature when integrating approaches.

Stuart seemed to articulate his understanding of the unknown effects of the TR in terms of evaluating effectiveness which may also have implications for evaluating the effectiveness of an integrated approach: "*you can't get the placebo effect in an RCT [randomised control trial]… how do you take out the therapist element?***"** In terms of the TR in the sense of face-to-face time with a client, he spoke about active listening and

emphasised his tendency to want to listen to the client rather than fit the client's needs into a prescribed model. This was a stance that he shared with Ann who also emphasised that integrating different modalities was firstly about '*listening to the client'*. Stuart, however, took this further:

> *I'm not very good at following CBT models because I tend to want to listen to what the client wants to talk about. You're supposed to set an agenda with CBT. Clients do come and say "I've been to see this therapist but they were too quiet. They didn't say enough. They were listening and understanding, which was lovely but it didn't seem to go anywhere and I need something a bit more interactive, somebody who'll actually chuck the odd idea at me, do more and get more of a response." I actually get that quite a lot, which I think is fair enough. That's probably what I'd want in therapy probably. I don't know if it's a difference in approach, because having done the existential course it means I'm very easy talking about issues about death and so on in different ways… It might just be a thing you bring that does make my hybrid approach work better.* (Stuart)

After his initial stance, Stuart diverged from emphasising the importance of listening to the client (rather than pre-determining the content of the conversation via an agenda) and highlighted the importance of active listening and interaction on the part of the therapist. In his view, it was this combination between the open listening and active listening - with subsequent suggestions '*chucked in'* that built the foundation for integration. Stuart had worked with clients who had critiqued other therapists for failing to have this balance. He emphasised how he would have wanted the same thing in therapy if he was the client. It can be said that this is a commonality that John, Robert, and Stuart share in their approach

towards integration; namely, exploring the *'internal'* as far as their client allows (i.e. listening), and then creating action - '*walking beside them'* (John), '*being a bridge'* (Robert), and '*going somewhere'* (Stuart).

Graham also spoke about this aspect of the therapeutic relationship indirectly: in relation to the case of pain/depression where he was just *'holding'* the conversation (where he expressed uncertainty about whether or not he could claim any success in the case); and how self-disclosure in the therapeutic relationship '*strengthens the relationship*'. Again, these were tangential references to it in addition to a lack of certainty/confidence about its relevance and how to enact it. Joanne did not discuss the TR *per se* but situated herself as client-led: "*I go with where the client's at…I guess I follow the client really*". Yet, by remarking how "*she went*" where the client went, she implicitly demonstrated how she had an active cooperative role in therapy.

For Mark, integration and the TR were issues that seemed intertwined with what might be conceptualised as the "*mystery*" of the TR process:

> *I [laughingly] wouldn't start from there and say "I'm mixing CBT and existential" or "CBT or existential and something else." I mean, you work with a client and the client takes you into places where, on reflection, you can say "Oh yes, that was quite an existential piece of work," ... but .... (the approach) has to be that which has been prompted by the client, not by you and it's in order to get that level of communication between the client and yourself, who might be very different and might have very different value sets ... to get that sort of level of*

intimacy where the communication is almost at a therapeutic level, which is almost a different level of consciousness. (Mark)

The mystery of this approach is conveyed through the notion of the therapist "*being taken to places*", and the communication of the TR being *"almost a different level of consciousness"* that is almost "*at a therapeutic level*". This '*mysterious*' type of relationship is described as being resonant of clients' inner worlds that John felt it important to walk in, and certainly evoked the language of ET more than that of CBT. However, this type of TR was also conceptualised as a conduit towards integration, as it not only necessitated a *"combination of approaches"*, according to Mark, but determined what those approaches were to be – *"that which has been prompted by the client, not by you".* Initially, Mark sounded as though he might be somewhat '*thrown*' both by the client and into the place of mystery and only gained awareness of the process retrospectively. Therefore, in his view, integration of modalities was a fluid process that was highly conditional on the evolving therapeutic relationship and the prompts of the client, contrasting with the approach of other respondents, such as John, who seemed to consciously determine the best approach to use while he was in the moment with the client.

Mark also spoke about the freedom that the TR provided in terms of paving the way for integration:

I never focused on an issue. If somebody comes in and they present an issue, now, I know that the presenting issue is never the real one, or very rarely is unless it's a real whopper like they've just been shot or something but I never listen. I

> *actually don't listen to the content of what they're saying, only how they're processing what they're saying and work with that.* (Mark)

The freedom and openness towards integration here emerged in Mark's ability to create the space for people to talk without imposing meaning on it from the start which had similarities to the one described by Stuart. The fact that he focused on the client's thought process rather than the issue itself, perceiving that this is *'never the real one'*, evoked the latent content-gathering dynamic implicit to ET rather than CBT. Nonetheless his overall commentary lends itself to highlighting how a focused and free-listening TR enabled openness to different issues and processes with the use of different modalities to deal with them.

Karen, similarly, valued the TR and discussed how this reflected the validity of integrated approaches:

> *I think one of the most important things to me is – and always has been – the therapeutic relationship. I will take a lot longer now getting alongside someone, getting to know them than probably a CBT assessment would allow for.* (Karen)

Here, the importance of integrating ET with CBT was implicit because on its own, the relationship enabled by a *'CBT assessment'* was not regarded as sufficient to enable getting to know a client as much as it would be necessary in order for their *'thinking and feeling'*

to be adequately understood. Therefore, a deep sense of understanding required the use of ET.

While the crucial element of trust and opening up to the therapist can be seen as fundamentally related to integrative approaches, it was not explicitly linked to the integration and its contribution. It was reflective in the way in which many respondents discussed the TR - practically all participants did it in a way that positioned it as an intrinsic psychotherapeutic process and implied intrinsic to integration itself. While the latter connection was not always explicitly drawn out (with Mark focusing on how the TR might offer a way through the issue of integration to the greatest degree), the fact that all participants employ integrative approaches in their work and also pay attention to the TR, it may not be unfeasible to link the importance of the TR to integration.

6.4.4 Integration: Concluding thoughts

In deconstructing this superordinate theme it would appear that, firstly, respondents' own personal and professional development determined their level of familiarity with the potential for integrating CBT with ET and their level of comfort in doing so. Above all, the findings here indicated the significance of practitioners' own self development, engagement with existential views in their own lives and, indeed, their own understandings of the self, as key to inspiring an interest in integrating ET with their CBT during and following their training. Training was another key factor affecting how the participants had personally traced the evolution of CBT approaches and how they had subsequently found it useful to integrate ET. This integration in their thinking and their practice was taking place in various forms- from 'organically' adopting it as and when

needed, to the view that there should be a more systematic grounding in each modality during training which would have allowed effective integration in practice.

However, it also appeared that integration was generally unsystematic in terms of the way it was applied in practice. For example, the respondents '*broke into*' after '*feeling their way towards*' it given the myriad of client circumstances that they encountered. Indeed, the ability to integrate in a flexible manner was often seen as a key skill in itself and an important part of practitioners' experience. This was not always an easy skill to build but several respondents recounted their struggle with integrating approaches. One such example was finding themselves at tension with CBT supervisors who were more fixed in their views and most of them experienced some discomfort at developing their own 'hybrid' approaches regardless.

Chapter 7 – IPA Discussion ('qualitative strand')

7.1 Introduction

The primary objective of the present study was to explore, qualitatively and in-depth, the situated, "*subjective, phenomenological flow*" (Vos, Craig, & Cooper, 2015, p.115) of integrating (or not) traditional CBT methods with ET tools. It sought to make contributions to the "*growing movement toward integration of psychotherapy schools*" (Sotskova, Carey, & Mak, 2016, p.37).

Despite the insurgence of this movement, "*empirical knowledge of eclectic and integrative psychotherapists is meagre (…) [and] has lagged far behind clinical practice*" (Norcross, Karpiak, & Lister, 2005, p.1787). Research to date has focused primarily on measuring quantitatively the (often comparative) efficacy of CBT for the treatment of well-defined psychiatric diagnosis, and often as it compares to the efficacy of alternative modalities (e.g., Cuijpers, 2013; van Etten & Taylor, 1998; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Hofmann, & Smits, 2008; Tolin, 2010). With some exceptions (e.g., Stiles, Barkham, Mellor-Clark, & Connell, 2008). These efforts contribute to our knowledge of establishing the scientific worth of modalities at some level of specificity.

Yet these methodological procedures leave space for the presumption that CBT therapists do not employ tools from other modalities whilst conducting CBT, and vice-versa. As this study showed, and some have empirically found (Lazarus, 2015; Lamparoulus, 2001), a considerable amount of psychotherapists nowadays confess to being integrative or eclectic, rather than orthodox and using solemnly and rigidly a single theoretical

modality and its tools (Lazarus, 2015; Norcross, Karpiak, & Lister, 2005; Sotskova, Carey, & Mak, 2016; Zarbo, Tasca, Cattafi, & Compare, 2016).

This methodological approach also leaves space for the presumption that there is a therapy that works better than the others for every individual and in every circumstance. Yet, as established in the introduction to this thesis, many researchers and practitioners acknowledge otherwise (Goldfried, 2009; Mulder, Murray, & Rucklidge, 2017; Norcross et al., 1995; Stileset al., 2008). The clinicians interviewed for the purpose of this study shared this very same opinion. This finding has been explained through the 'common factors' hypothesis, which states that the therapeutic success rests upon factors shared by every modality, and the granularity hypothesis, which shows that very specific tools of diverse therapies are efficacious for different issues of the same condition (Hetzel-Riggin, Brausch & Montgomery, 2007) or subgroups of the population (Butler et al., 2006).

The emphasis on efficiency (vs. efficacy), that is, the speed through which an outcome is achieved, has been aggravated by the various financial constraints in worldwide economy, and particularly those experienced by therapists and their clients undergoing NHS-subsidised therapy (e.g. Butler et al., 2006). This may lead to an oversimplification of the therapeutic process, and a disregard of utterly critical, but less easily quantifiable or more time-consuming variables. As it will be explored in this chapter, the therapeutic alliance is one of these eventually institutionally devalued factors.

This introduction sketched the main research issues born out of the study of the integration of psychotherapeutic schools. Firstly, a brief description of the themes identified during the analysis of the interviews of eight British CBT therapists is offered.

It follows a succinct discussion of participants' perceptions and uses of integrative approaches. Subsequently, one of the main and most recurrent topics in these interviews is explored. Then, tools identified as lacking in CBT, and which are made available by alternative approaches, including and particularly ET, are explored. The final three sections are concerned with methodological issues, such as limitations and strengths of this study and future research directions.

7.2 Main themes

The IPA analysis of participants' interviews yielded three main themes. One was the 'Assertion of the human' theme, comprising five subthemes (Superficiality versus depth; Structure versus fluidity; Client presentation and preferences; Power dynamics; and The wounded therapist). This theme identified the practical issues raised by the utilisation of any psychotherapeutic modality, taught principally by the modality to which every participant subscribed: CBT. For instance, some participants discussed some of the power issues involved in any consultation. They noted that in IAPT-guided, NHS-funded CBT settings, the decision-making power rested mostly on institutions, then on the therapist, and finally on the client. Conversely, more humanistic orientations tended to assign more power to clients, and less institutional settings allowed more autonomy to therapists.

Then there was the 'Missing elements' theme, with five subthemes (Theoretical and practical gaps; The 'human' gap; The authenticity gap; The 'meaning of life' gap; and Gaps in ET). This theme was fundamentally important for identifying the therapeutic tools perceived as lacking in their mostly CBT-oriented practices, but also in other modalities. This was done eventually in comparative terms, and without an objective identification of how that tool might be added to the reference modality. For instance,

participants noted that CBT lacked depth in its understanding of clients' experiences, whereas the same was not observed in more humanistic approaches.

Note that these 'lacking in tools' do not necessarily presuppose the use of frameworks other than the ET. Nevertheless, these are suggestive that, from the viewpoint of interviewees, a modification of what was currently at their disposal was needed. By filling in these gaps, the scope and the positive outcomes of therapy could be arguably enhanced.

Finally, there was the 'Integration in practice' theme and its three subthemes (Personal and professional background; The unsystematic nature of integration; and The therapeutic relationship). This theme illuminated participants' perceptions of whether, why, and how they integrated ET and CBT in their practices. Nevertheless, some participants had but a very vague understanding of the theoretical underpinnings of ET and integration. They further had rather implicit integrative practices.

This non-explicit and/or thorough knowledge of both integration and ET had an advantage. It might have helped to have a more ET-unbiased perspective on how participants felt about their CBT practices. Yet, it had clear disadvantages. Firstly, it was rather difficult to arrive at an in-depth understanding of how participants perceived both integration and ET. It also gave rise to the necessity of conveying a potentially biased (i.e., ungrounded upon participants' narratives) attention to ET subsequently, during data analysis and the discussion of findings. That is, the links established here between ET and gaps are mostly driven from theoretical considerations, grounded as best as possible on participants' likely unbiased understanding of the missing elements of CBT, their apparently vague understanding of the tools offered by ET, and of integrative practices. In the following section, findings concerned with integrative practices are detailed.

7.3 Integration practices

Overall, interviewees found it difficult to clearly define or explain how they integrated different approaches in practice. Thus, little evidence about integration strategies was gathered. Nevertheless, every participant grounded the practice of integration on the importance of attending to the needs of individual clients *(Ref: The unsystematic nature of integration)*. Thus, they seemed to support implicitly the granularity hypothesis.

Specifically, participants reported that they made use of different approaches whenever they so deemed relevant for that particular client or circumstance. This decision might derive from clients' explicitly expressed dislike of CBT and its techniques, or therapists' own judgement of the unsuitability of CBT for that client or circumstance. *(Ref: Meaning in life gap and theme - The unsystematic nature of integration)* In either case, referring to a tool from approaches other than CBT was not usually an act planned at the beginning of the CBT process. It was rather a deliberate and situated decision that emerged whilst the therapeutic process was ongoing; it was a circumstantial reactive remedy. As such, their integrative practices were qualified in the preceding chapter as fluid, or organic; interviewees demonstrated having an unstructured form of practicing integration.

Some interviewees expressed, implicitly or explicitly, doubts about their own (and/or about CBT therapists' in general) knowledge of alternative approaches to CBT and how to best integrate these in their practices. Several additional observations pointed in the same direction. Firstly, younger participants were less inclined to speak of the philosophical origins of CBT and/or ET, and were less comfortable comparing the two approaches. This suggested that younger participants had a narrow scoped and limited

knowledge of the theoretical origins of modalities, of alternatives to CBT, and/or of clients' conditions.

Secondly, some participants referred to their early philosophical beliefs as stemming from Rogerian humanistic approaches and yet failed to link this background to ET practices. Participants surprisingly also did not discuss how particular modified iterations of CBT, e.g. ACT or REBT, were, in a sense, integrative approaches; these might help to meet clients' needs in more holistic, flexible, and/or existentialist ways (Greenberg & Watson, 2006; Mearns, Thorne & McLeod, 2013: Sotskova, Carey & Mak, 2016). This lack of outward discussion might have contributed to their difficulties in explaining how integration was practiced. Yet, this lack was not necessarily due to a lack of interest. There may be pressures to overlook approaches other than CBT in CBT-oriented trainings. Secondly, ET in particular is an approach that is filled with controversy, or better said, idiopathic understandings of what it is; "*people actually used [and still use] the term existentialist in very different ways"* (Cooper, 2016, p.vi). Thirdly, attempts at crafting a framework for the integration of CBT and ET are at best at their beginnings (Sotskova, et al., 2016).

Finally, there are diverse ways of conceptualising what integration is and how it can be best implemented. For instance, Sotskova et al. (2016) distinguished between the 'technical eclecticism' (i.e., choosing tools from other approaches without clear understanding of their theoretical underpinnings and contextualising framework), and 'assimilative approaches' (i.e, having a strong reference modality and critically employing tools from other modalities for complementary purposes). The latter would be preferable as discussed in the literature review (Chapter 2). Its use would allow, as argued

and for exemplificative purposes, to address the "*cognitive symptoms of PTSD, such as survivor guilt and self-blame, and existential conundrums, such as a sustained moral injury*" (Sotskova, et al., 2016, p.39) under the same modality.

Alternatively, in the field of medicine, a distinction between combination (i.e., combining Western and non-Western alternatives, as needed) and integrative medicine has been made. According to Bell and colleagues (2002, p.133) "*combination medicine (…) is not integrative. Integrative medicine represents a higher-order system of systems of care that emphasises wellness and healing of the entire person (bio-psycho-social-spiritual dimensions)*" (Bell et al., 2002). Thus, in medical and psychotherapeutic disciplines alike, there are those making clear distinctions between a more structured and and a less structured form of integration.

When one claims to be integrative because one is adopting a tool from an approach other than one's reference modality, then one is possibly simply combining tools and being eclectic. In the absence of more structured forms of integration, this is the type of integration that is possible. These respondents seemed to adopt this type of integration. They emphasised they practiced integration reactively, as a function of clients' needs and their clinical judgement, although this was not talked about consistently. *(Ref: Meaning in life gap and The unsystematic nature of integration)*

Throughout these interviews, and inclusively while discussing integration, two opposing attributes were recurrently mentioned. These were that of structure and flexibility. For these CBT-practicing participants, flexibility was needed for being integrative. These attributes will be unpacked in the following section.

7.4. The value and limitations of flexibility and rigidity

The language used by participants to describe CBT and ET suggested a dichotomy. CBT tended to be described by words that reflected an impersonal, structured and/or rational approach, such as '*rigid*', '*mechanistic*', '*structured*', and '*dogmatic*'. Alternatively, ET tended to be described through words that reflected a more complex, emotive or sensitive approach, including '*fluid*', '*depth*', '*creative*', and '*holistic*'. This dichotomy emerged recurrently while analysing the interviews, where it was applied to several distinctive abstract concepts (e.g., 'superficiality versus depth' and 'structure versus fluidity'). It consequently greatly shaped these findings. It will be explored in this chapter as referring to an opposition between rigidity or structuredness, and flexibility or unstructuredness.

Those participants who had greater knowledge of therapeutic trends and their philosophical origins assigned to 'classic CBT/REBT' attributes that resembled those assigned to ET. On the other hand, attributes assigned to 'contemporary CBT' were often polar opposites of those assigned to ET and 'classic CBT/REBT'. This suggested that, for them, CBT was not originally conceived as presently practiced. *(Ref: Superficiality versus depth)* Originally, the thus 'classic CBT/REBT'' resembled ET more, and partly because it was more flexible than 'contemporary CBT'. It did not have pre-defined treatment formulas. This observation is congruent with the literature, where it is noted that CBT's main founders actually advocated that treatment should be developed in collaboration with clients according to their individual needs (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Kinderman & Laptobban, 2000).

On the other hand, the henceforth named 'contemporary CBT' was perceived as more mechanistic, symptom-focused, structured, formulaic, and a 'one-size-fits-all' approach to therapy (than ET and classic CBT/REBT). *(Ref: Superficiality versus depth and Structure versus fluidity)* It was rather 'manualised', outlining precise steps to which therapists were expected to adhere in certain circumstances (Taubner, Zimmermann, Kächele, Möller & Sell, 2013). The purpose of this procedure is the provision of standardised, uniform treatment (vs. customisable treatment; Taubner et al., 2013), and objective ways of measuring results. Thus, rigid approaches to therapy, among which 'contemporary CBT' can be found, see as unforthcoming the adaptation of treatment to any potential source of variability, including the condition, clients, and unfolding responses to treatment and changes.

Its underlying rigid structure was sometimes emphatically described has having merits, purpose, and efficacy. *(Ref: Structure versus fluidity*) It seemed to be greatly useful when clients were in need of seeing their cognitions structured. It also seemed adequate for dealing with, for example, stress, anger, and self-esteem issues as these presented themselves with depressive or anxiety disorders. Several studies support these practitioners' claims (Butler et al., 2006; Cuijpers, 2013; van Etten & Taylor, 1998; Hofmann, Asnaani et al., 2012; Hofmann, & Smits, 2008; Mansell, 2008; Tolin, 2010).

The perceived rigidity of 'contemporary CBT' was also, in some cases, lauded by respondents as better than ET at helping to devise, assess, and replicate the therapeutic process. That is, therapists' attraction to 'contemporary CBT' partly derived from it providing the means for planning and measuring the effects of their interventions with clients. It enabled therapists to acknowledge and learn what worked best with each client

or circumstance and potentially by-passed the need for actual feedback from clients in moments of insecurity or doubt. Additionally, clients could easily assimilate and take home the techniques that were most useful to them.

Thus, 'contemporary CBT' was viewed as more rigidly structured, and eventually beneficially so. Yet, some interviewees criticised this very same quality of 'contemporary CBT'. The disadvantages of such structured, symptom-focused, standardised, objective approaches to 'contemporary CBT' advocated by IAPT and NHS included its inherent inflexibility. 'Contemporary CBT' was inherently unable to adapt to different circumstances, and serve the interests of every client. As per participants, examples of situations less well served by 'contemporary CBT' included those involving: shifting, complex, atypical and/or unclear symptoms of known psychiatric disorders; reactions to external events beyond clients' control (e.g. death of a loved one); suffer-inducing philosophical questions (e.g., 'why did this happen to me'); and moments where clients felt lost. *(Ref: Client presentation and preferences)*

By advocating that each difficulty was better treated via different modalities, and that situations less well served for by 'contemporary CBT' demanded for the use of integrative attitudes, participants appeared to subscribe to the aforementioned granularity hypothesis. Another underlying implication of interviewees' 'contemporary CBT' practices and their perceptions of it, was that being flexible (i.e., adapting to different circumstances and clients) necessarily translated into being integrative. Tools outside IAPT's box were needed for dealing with non-manualised circumstances. That is, being integrative and flexible became quite equivalent terms in this study. To become flexible, participants

recommended the adoption of an observant attitude. Therapists should become more intuitive ‘followers’ and sojourners on their clients’ journeys and explorations.

This stance echoed Rogers’ (Rogers,1957/2007) humanistic, client-centred approach to therapy. It also echoed the principles behind the principles of ET (e.g., Deurzen & Adams, 2016; Smail, 1978), which propose that the authentic becoming of clients is a dynamic, ongoing, emergent, and relational process. Consequently, clients’ conditions cannot possibly be adequately illustrated by the ‘screenshot’ of clients’ issues, which is taken during the first sessions of ‘contemporary CBT’ therapies (Deurzen & Adams, 2016) and which guides, thereafter, in a manualised manner, therapeutic procedures. These two conceptualisations of ‘conditions’ are not easily compatible.

Additionally, some respondents, including those valuing structured approaches, explicitly professed their belief that continuously following the same strategy with all clients, and continually so over time, was detrimental. This claim is congruent with the stance of existentialists like Weinstein and Henrich (2013) and Smail (1978), who claimed that flexibility was a therapeutic necessity. Although the reasons for this were not detailed by interviewees, it seems reasonable to posit that rigidity possibly stunted their ability to relate or adapt to different clients. This disadvantage was said to afflict both ‘contemporary CBT’ and guru-like versions of ET *(Ref: Structure versus fluidity).*

Finally, criticism of ET (or of that which participants conceived as ET) involved it being unstructured, flexible, and lacking in well-defined techniques and outcome measurements. This mirrors what was observed in regards to the advantages and disadvantages of structured approaches. That is, both structure and lack thereof had pros

and cons; no solution was one-size-fits-all. This ambivalence might have fuelled their silence over their discontent with the manualisation of CBT. Secondly, as it will be discussed in the following section, within their highly structured CBT-oriented settings and frameworks, flexibility and fluidity were not necessarily easy to implement. These difficulties might have fuelled their expressed discontentment with excessively or improperly structured approaches (though not overtly, or necessarily, CBT).

7.4.1 Limitations to flexible and client-led approaches to therapy within 'contemporary CBT' frameworks

According to interviewees, the current teaching and practice of 'contemporary CBT', and most critically in IAPT-guided and NHS-funded settings, was seen to be in conflict with their widespread belief that the therapeutic process should be client and flexibly led. Among the obstacles created by their professional settings to the adoption of more flexible approaches was, firstly, a narrow-scoped education and training. Knowledge and guidance about how to proceed when faced with CBT's underperformance, or inadequacies, was generally not provided. In the best-case scenario, participants sought knowledge of alternative approaches or integrative stances by their own personal accord. Their professional settings did not support, and some even actively censored, these initiatives *(Ref: - The unsystematic nature of integration).*

Secondly, their professional settings incentivised the utilisation of 'contemporary', IAPT-guided and NHS-funded CBT. *(Ref: Key gaps in ET, Personal and professional background, Structure versus fluidity, Power dynamics and the wounded therapist).* As the findings suggested, this approach was perceived as more superficial (i.e., detached from the richness of the diversity and uniqueness of clients' conditions), structured (i.e.,

more formulaic, manualised, symptom and technique-based), and detached of circumstantial aspects. Probing these views indicated that participants experienced a sense of frustration with the UK's current mental health policies and their emphasis on the quantification and standardisation of CBT *(Ref: Structure versus fluidity).*

These healthcare industry standards and practices advise therapists to focus on manualised techniques, active guidance of the therapeutic process, and well-circumscribed conditions and treatment plans. Through these emphases, practitioners are actually being recommended to take a back seat on clients' explorations, even in those aforementioned situations where therapists and/or clients feel at loss, conditions shift, and so forth. Therapists are further being recommended against changing their initial decisions and approach, and adapting to the therapeutic process, the client, and the presentation of issues, as these change over time. They are being recommended against the enactment of client-led approaches and flexibility (Clark, 2011; Paley et al., 2008; Clark, Fairburn, & Wessely, 2008).

This situation was something of which participants were aware and some apparently disliked, but were not, as noted, necessarily vocal about actively resisting. What they were vocal about instead was how their institutional, educational, and professional settings shifted power away from the therapist, thereby restricting their ability to draw on their own expertise or preferences while conducting therapy. As funder, the NHS does have veto power over practices that have not been proven (quantitatively) to be efficient, and does enforce a 'conveyer belt' atmosphere of care (Osborne, 2013).

The structured learning associated with 'contemporary CBT' aims to provide a safety net to clients and to insecure practitioners. Yet, it could make clients feel like a number, as Griffiths, Steen, and Pietroni (2013) proposed and these interviews discussed. Karen, for example, recounted having patients come to her after seeing another CBT therapist and commenting *"I could tell I was just a number".* Likewise, Ann commented*, "the experience (of CBT) is linked very much into the categorisation of people",* making the ideal CBT practitioner, according to her, a *'business person'.* Moreover, if clients learn the rigid approach to mental health issues and stick to the tools offered by the therapist, they might see stunted their ability to independently experiment with what works best for them in their less structured environments. Ryan et al. (2011) also pointed in this direction when discussing how the lack of personalised attention, care, and customisation in the therapeutic process can negatively impact clients' motivation to manage their own symptoms and conditions.

In line with Smail's (1978) arguments on power and power dynamics, participants felt there was an underlying pull towards a power imbalance in therapy *(Ref : Power Dynamics).* Therapists were trained to be essentially in control, but beneficently so. This, however, appeared to neglect the reality that, in such a relationship, there can be no genuine beneficent control. Both the client and the therapist must possess the lion's share of autonomy and authority in how to work out their issues and move their life forward (Smail's 1978).

Under the present regulatory forces, clients may, against their own advantage, delegate responsibilities on therapists, and therapists may, against their own advantage, delegate responsibilities on IAPT guidelines. A similar argument was put forward by Shanaya et

al. (2008). These authors reported that the term 'treatment resistance', used by therapists to describe those for whom CBT was ineffective, was merely a reflection of the ego of those within IAPT. Those invoking the argument of 'treatment resistant' when faced with the inefficacy of their therapeutic methods would be resisting themselves. They would be resisting to take the time fully to engage with clients, refusing to acknowledge that a specific recommended treatment was inefficacious or unsuitable for some clients' circumstances, resisting to acknowledge their own faulty judgement, and/or unwilling to recognise the value of alternative approaches, and so forth. It also located the problem in the client rather than in the context (i.e. wrong therapy, wrong time etc).

Overall, NHS and IAPT guided CBT modalities were argued to constrain the creativity, skill, freedom and power of therapists in the context of therapy, of clients in their daily lives, and the value of the therapeutic alliance. The finding that several therapists found pure CBT methods unsettling and 'cruel' on a personal level suggested that they were not at ease with what was being demanded of them. *(Ref: Wounded therapist* , Illustrating this, CBT was described at various points in the interviews as '*cold'*, an '*angry headmaster', 'excluding', 'cruel', 'abusive'*, *'painful', 'exposing', 'disastrous', 'mechanistic', 'dangerous and traumatising', 'rigid',* and *'stressful')*. It also showed that for some therapists such lack of control over their practices was not welcomed. It rather was an emotional journey that was wounding to both client and therapist. It dehumanised the experience and process for both therapists and clients, and inhibited full disclosure.

These deficits were perceived by the participants to be a precursor to suboptimal outcomes. 'Contemporary CBT', and principally in its standardised format, usually targets, via pre-specified techniques, the way participants deal with their symptoms as

these relate to set categories of diseases. CBT was apparently aligned with a more medicalised approach to mental health. The pivotal points are firstly, the psychiatric diagnoses, secondly the understanding of the client's issues, and lastly, the planning of how to therapeutically address them. The focus is upon symptoms, not people.

This seems to reflect a pre-Rogerian therapy mindset, in which the medicalisation of mental health supersedes any other approach or concern, including humanistic and relational ones. Yet, all interviewees, and very much in line with available empirical evidence (Ardito, & Rabellino, 2011; Baldwin, Wampold, & Imel, 2007; Flückiger, Del Re, Wampold, & Horvath, 2018; Horvath, & Symonds, 1991; Josefowitz, & Myran, 2005), emphasised the value of the therapeutic alliance and the need for being flexible and adaptable it created. Thus, the medicalisation of mental health seems to be at least partly in conflict with current evidence, and with the beliefs of these interviewees.

In conclusion, there was the widespread impression among participants that more systematic and automated approaches within CBT ('contemporary' CBT) were being promoted in order to meet the political, social, and economic requirements of IAPT and government targets. These pressures transformed therapy into a slightly superficial, mechanist, rigid, dependency-creating, and inhumane process. Similar criticisms have been raised by those arguing that the current NHS approach to CBT adversely impacts mental health provision in the UK (Rhodes & Jakes, 2009).

7.5 'Lack of tools'

In this section, 'Lack of tool' refers to the gaps (sub-themes: Theoretical and practical gaps The 'human' gap, the authenticity gap, the 'meaning of life' gap, Gaps in

existentialism) i.e., constructs descriptive of unmet needs of clients, therapist, and therapeutic processes, identified by participants within contemporary, IAPT-guided, NHS-funded CBT modalities. Interviewees did not explore systematically which alternative tool or modality helped to address the set of gaps they identified. Nevertheless, it seems useful to do so, even if merely from a theoretical viewpoint (i.e., somehow disconnected from participants' narratives). Given the topic of the present study, particular attention will be given here to existentialist tools, and their relation to the identified 'tools-in-lack'.

This discussion intends to clarify whether a framework integrating CBT and ET might or might not be useful for therapists and point in the direction of avenues for the improvement of 'contemporary CBT' practices. Both purposes are regarded as a research interest. For instance, a recent meta-analysis of 70 studies conducted by Johnsen and Friborg (2015) reported that CBT has become less effective over time. It is here proposed that such a state of affairs can be partly explained by the obstacles to flexibility in practitioners' professional settings detailed in the preceding section, and the 'tools-in-lack' that are to be explored in this section.

The process of identifying a gap, and developing tools or frameworks that address it, can be said to help to characterise most, if not all, integrative versions of CBT. For instance, the neglect for the living environment of clients, such as their employment status, has been identified as a factor contributing to the low success rates of 'contemporary CBT' (Rathod et al., 2010). Many third-wave iterations of CBT, such as the Hayes' ACT, target this gap by seeking to consider clients' experiences from within the psychological and social context in which these occur (Hayes et al., 2006; Hayes, 2016; Zettle & Hayes, 1987).

In the following sections, tools-in-lack that are made available by alternative approaches, particularly ET, are discussed in more detail.

7.5.1 Rogerian, client-centred approaches

All participants talked about the importance of establishing a relationship with their clients *(Ref: Therapeutic relationship)*. Some of these respondents further equated 'integration' with client-centred approaches to therapeutic relationships. This suggested that they felt that 'contemporary CBT' was lacking in utilising the therapeutic alliance in the humanistic sense of alliance, and which enactment translated into an integrative form of CBT.

Historically, client-centred therapy was greatly developed by Rogers in the middle of the 20th century. He advocated that therapists should relate empathically to the clients' ongoing presentation without judgement (Rogers, 1957/2007). This 'sensitive attention to the psycho-physiological flow' of clients' experiences was to be contrasted with the active manipulation of the therapeutic process that could be observed in modalities like rational-emotive and drama therapy (Rogers, 1975). By pointing in the direction of some possible meanings of the intuited experience, the therapist would help the client to give meaning to ongoing experiences, driving learning and change (Rogers, 1975). This moment-to-moment, intuitive, non-censoring relation to clients' experiences was, and still is, seen as the cornerstone of successful therapeutic processes in client-centred frameworks (Rogers, 1975).

By identifying the Rogerian therapeutic attitude with what it meant to integrate different approaches, participants were thereby suggesting that a gap in IAPT guided approaches was the establishment of an empathic and acceptant relationship with clients, where they were more observant companions than active guides.

Only professionals who draw upon one and only one of the tools described by Rogers to complement another modality can claim they are being 'integrative'. If that therapist is uneducated about Rogers' overall stance, as such commentary suggested, they may even misunderstand what the empathic relationship is all about, and inadequately apply such tool. A similar argument was put forward by Sotskova et al. (2016, p.38) while discussing the dangers of "*technical eclecticism*", that is, the enactment of integration without an integrative theoretical framework behind, or deep knowledge of the modalities behind the development of specific tools.

There are a considerable number of approaches beyond client-centred modalities valuing the therapeutic relationship (Teyler & Teyler, 2014). Although each modality's understanding of alliance shows "*more similarities than differences*" (Teyler & Teyler, 2014, p.334), each tends to highlight distinctive aspects. Under ET frameworks, the establishment of meaningful relationships with the world (and, thus, logically, necessarily with the people in it too) is critical for the existence of the world and the self (Yalom, 1980). It is this relational link that allows for identities to form. Its accent is on the intersubjective and 'interobjectal' nature of existence. Rogers did not embrace this view. He was more phenomenological (Meneses, & Larkin, 2012), proposing there was a 'real' psycho-physiological flow, an 'essence', to which some meaning might be checked against for accuracy (Rogers, 1975).

These discussions may at face value be understood as illustrative of the 'common factor' explanation of therapeutic success. Yet, what this study clearly showed was that the notion and use of alliance was not a uniform common factor across approaches, as Norcross et al. (1995) had suggested. There are distinctive ways of conceptualising the therapeutic relationship, from being "*engaged in collaborative, purposive work*" (Baldwin, Wampold, & Imel, 2007, p.842), to the herein detailed Rogerian view. The latter was seen as lacking from 'contemporary CBT', and proposed as critical for therapeutic success by the interviewees.

In sum, according to participants, 'contemporary CBT' acted relationally more like a computer, labelling clients' explicitly communicated experiences under a set of pre-existing categories for choosing among well-known therapeutic solutions. The inability to use (for computers) or lack of (for 'contemporary CBT' modalities) empathy-as-tool might explain why the therapists from Becker and Jensen-Doss' (2013) study were concerned with the damage computer-assisted therapies might cause.

7.5.2 Existentialist tools-in-lack: Adaptation, authenticity, depth, becoming, therapeutic relationships, and holism

Per participants' perceptions, 'contemporary CBT' was unable to, or uninterested in allowing clients' emotional perspectives and buried feelings to come to the fore. It was also unable to engage with existential issues, i.e., the 'big questions' *(Ref: Missing elements)* that clients were sometimes grappling with and potentially lied at the root of certain crises. It further operated in a 'timeless' atmosphere; clients' issues were not contextualised in their chronological unfolding. Finally, it was reductionist; it did not

understand experiences in their overall context. These were four types of lack of 'depth' in 'contemporary CBT'.

Traditionally, CBT holds a logic-focused and rational approach towards what may be turbulent and often irrational inner landscapes. As noted by some participants, this can be understood as an attitude of wanting to 'fix' people's problems, with fixing being directly linked to the medicalisation of mental health (Aho, 2008) *(Ref: The human gap).* Traditionally, medical professionals had the directive to 'fix' and, to the extent possible, 'cure' problems, and usually through the intervention of very specific medical specialities (Bell et al., 2002; Wade, & Halligan, 2017; Olney, 2015). It was only more recently that medical professionals started to be alerted to the importance of targeting clients' general wellbeing, and eventually address dimensions other than the biological or physical (Wade, & Halligan, 2017).

Alternative approaches such as ACT and the concept of acceptance, Rogers' and the concept of unconditional positive regard, and ET and the concept of adaptation are both more holistic in their understanding and less rejecting. With these tools comes the presumption that problems sometimes cannot or should not be 'fixed' or 'cured.' Problems are not an instance to discard or reject. Rather, sometimes individuals must simply accept, manage, and adapt to their overall and specific conditions; learn how to live better. This holistic and all-embracing attitude is argued to be embodied by therapists from these traditions through the way they relate to clients and their moment-to-moment experiences – and in such way that clients learn to do the same (toward themselves and possibly others too). If this reasoning is applied to 'contemporary CBT' as herein described, clients would learn instead mechanist, rejecting attitudes, internalising that part

of themselves, and possibly more, is irrelevant, problematic and/or worth of being rejected.

ET does not regard clients' suffering or suffering-inducing issues as signs or symptoms of illness that must be gotten rid of. Indeed, ET actively seeks to *"resist the pull towards systematisation and reification*" (Cooper, 2011, p.xix). It posits that life is a process of ailments and adaptation. It is a process of becoming, authentically, through self-generation, acceptance, and adaption to one's own, and overall circumstances. Adapting and coping better with whatever instance would be a sign of improvement, or even evolution (Adler, 2012; Kleinman, Eisenberg & Good, 1978; Sotskova et al.k, 2016; Zoellner & Maercker, 2006). The implication is that, under existentialist frameworks, there is no healthy state to which one must return, after having one's broken leg fixed. What is healthy is the process; the way. It is not the destination.

Then, therapists and clients adopting existentialist approaches must acknowledge that living is a process of changing that takes time (Papadopoulos, Fox, & Herriott, 2013). As long as one is taking the time to authentically bring to life one's issues, and thereby self-generate and transform, one can be deemed healthy. To teach their clients to act so, therapists must, just as with humanist approaches, be utterly respectful, but also, and most critically, non-dogmatic, and unknowing of what the future will bring (Cooper, 2011). Unlike humanistic traditions, existentialists embrace the ambiguous and temporary character of beings more markedly. For them, development does not necessarily march towards the positive direction of greater and better fulfilment, personal development, or mental health. Thus, ET teaches to clients that they must trust the process of becoming. There is no goal except for that of allowing oneself to experience authentically.

In conclusion, according to this review, IAPT-guided CBT holds several tools-in-lack. Gaps that ET may serve to address include the teaching/learning attitudes of adaptation, uncertainty, authenticity, depth, becoming, therapeutic relationships, and holism.

7.6 Conclusions and discussion

7.6.1 Understanding dualities

While the aim of the current study was to explore the ways in which therapists integrate CBT and existentialist approaches, the interviews themselves tended more towards a discussion of gaps perceived in 'contemporary CBT', as compared to its alternatives. This tendency may be reflective of the wider conversation currently happening within mental health services about how to aid practitioners in supporting their clients.

For most participants, no approach was seen as perfect in and of itself. Each had its own advantages and disadvantages. ET was criticised for being unstructured, fluid, and lacking in set techniques and outcome measurement tools. CBT did not suffer from such flaws, and was conversely subjected to criticism for being too structured, technique orientated and focused on measurement tools. CBT's objective measures and process standardisations were born from a need to better understand whether or not clients were being truly aided, and how to best serve them by knowing what works and what does not (Borntrager, Chorpita, Orimoto, Love & Mueller, 2013). This has likely fuelled the promotion of CBT by government bodies (Price & Anderson, 2011). Yet, these measurements may have been done to an inadequate extreme, and only in regards to variables that can be more easily quantifiable. ET, on its own, appears to be an extreme as well. Clients can become too lost in exploration if there are insufficient steps,

processes, and procedures to support their being grounded, both personally and interpersonally, in their experiences (Borntrager, et al., 2013). This radicalisation of modalities might have contributed to the dichotomy involved in participants' perceptions.

As previously discussed, some participants referred to CBT as being a 'safe' manualised modality because of the concrete parameters it conferred to treatment choices. While this can confer a certain level of comfort to therapists, principally when younger and less experienced (Hogarth et al., 2018), previous research has shown that its parameter-bound efficacy is sometimes short lived (Butler et al., 2006), increasingly lower (Johnsen & Friborg, 2015), equivalent across modalities (Mulder, Murray, & Rucklidge, 2017; Stiles, Barkham, Mellor-Clark, & Connell, 2008), and/or specific to subcomponents of some condition (Hetzel-Riggin, Brausch & Montgomery, 2007) or subgroups of the population (Butler et al., 2006. This would suggest that there is some degree of illusion when thinking that CBT's efficacy is to be taken for granted.

More experienced therapists had more knowledge or in-depth training in ET and other alternatives, demonstrated less difficulties discussing similarities and differences across approaches, and were more relaxed in their eclectic or integrative practices. They were more aware of treatment differentials and their nuances. Hence, one way of addressing the insecurity of younger participants might be precisely the provision of more diverse training and experience. This could inclusively lessen the structure-flexibility duality that emerged from these findings.

7.6.2 Integration

This was the unsystematised, unplanned, intuitive but deliberate nature of respondents' integrative practices. When being flexible, some claimed, they were being integrative. As discussed, this conflation is understandable through the differences between IAPT-guided, NHS-funded CBT and 'classic CBT/REBT' that some participants explored explicitly.

This distinction highlighted how, whenever participants described CBT as inflexible in general, they manifested some lack of knowledge of the history of CBT. This lead to the addition of the adjective 'contemporary' when discussing CBT's shortcomings in this chapter, for it was IAPT's version that likely was on their minds. Yet, it is also possible that 'classic CBT' was regarded by some as inflexible as well. Although this was not explored in these interviews, Rogers (1975) might hold this very same opinion. This is partly because however more flexible classic CBT/REBT might be, it is still less flexible than many other alternatives, including client-centred and existentialist approaches. Therefore, the established dichotomies may still hold for contemporary and classic CBT/REBT alike.

However imprecise their understandings were, integration was said to be applied as a function of each therapist's own understanding of the philosophical underpinnings or tools of each approach, the needs of their clients, and/or the therapy's goals. This illustrated they apparently held a combination or eclectic understanding of integration. It was deemed necessarily in a granular sense, to be therapeutically efficacious in specific circumstances.

Participants did not discuss in detail how they overcame practical barriers to achieving integration, or how they applied it. That is, this study's findings suggested that integration was regarded as therapeutically beneficial, but were less specific about how it could be enacted. For instance, the nature of ET may (Cooper, 2009) or may not (Strasser & Strasser, 1997) mean that therapy lasts for a considerably long period of time. It appears unknown what a CBT therapist integrating ET (or other potentially lengthier approaches) can do, duration-wise, when seeking to combine or more fully integrate these approaches.

From reviewing the literature on both cognitive-behavioural and ET approaches, and using the findings that emerged from the analysis from the interviews in the current study, it appears that CBT and ET may be, as suggested by Sotskova et al (2016), compatible. The criticisms made against CBT were similar to the factors for which ET was commended, as if these were two sides of the same coin (Kim, Wamold & Bolt 2006). These include focusing on clients' needs more passively, bringing depth to the therapeutic experience at several levels, and allowing for a dynamic, moment-to-moment therapeutic process of adaptation and transformation to unfold, as based on client-therapist relationships. These qualities can possibly amount to the added value of integrating ET along with CBT. It might allow, for instance, therapists to teach their clients to look at great sadness as neither good nor bad. It would simply be both a symptom of depression and a natural, vital part of becoming, soon to be transformed in some other experience.

Yet, respondents' difficulties in explaining integrative practices in concrete terms may be revealing of greater underlying difficulties to integration. For instance, the attitudes therapists are advised to adopt under each approach can be incompatible. One would have to master the ability to be very directive whilst simultaneously being very empathic,

which is not necessarily easy to accomplish. Teyler and Teyler (2014) and Starck (2008) put forward a similar argument. They posited that young, trainee therapists and CBT practitioners had difficulties adapting to emerging issues in clients, with theprocessed experiential flow involved in immediate therapeutic relationships. These individuals found it difficult to not just empathically customise on a temporal basis, but also specifically to improvise; to work without a previously outlined structure. Hence, they turned to *"more prescriptive therapies that focus solely on the presenting problem"* (Teyler & Teyler, 2014, p.334).

As predicated on the narratives gathered for this study, younger therapists felt 'contemporary CBT' was reassuring and had difficulties explaining integrative practices. Only more experienced therapists were more at ease discussing and integrating modalities and/or engaging with the here-and-now experiences that are not core for 'contemporary CBT' approaches. These findings provide some convergent validity to Teyler and Teyler's (2014), while simultaneously raising questions about the practicalities of integration, principally for younger trainees and in the absence of proper training. Participants actually reported that they had found little in the way of guidance for integrating CBT and ET in practices, besides their own personal (at times professionally pursued) interests. This lack of guidance might have further contributed to their difficulties discussing their integrative practices; intuitive knowledge was their main mentor.

7.7 Strengths and limitations of this study

IPA is a methodological qualitative approach developed for the purpose of understanding individual lived experiences, and the meanings each individual ascribes to these

experiences (Smith, Flowers, & Larkin, 2009). The decision to employ qualitative research methods was congruent with existential stances. These are keen on understanding the dynamics of subjective experiences, and may show some "*reluctance (...) to engage with quantitative research methods*" (Vos, Craig, & Cooper, 2015, p.116). Nevertheless, both types of approaches can be argued to bear meaning and be helpful for the unveiling of subjectivity.

During these interviews, it was noticed that both participants and the interviewer were less used to engaging with one another under the informal, non-clinical, conversational atmosphere enabled by IPA interviewing techniques. This was predicated on, for example, some of the interviewees' laughter and fidgeting at the onset of interviewing. At the end of the interviews, virtually every participant demonstrated shifts in their demeanour, appearing more relaxed, as interpreted from their looser body language. Additionally, they engaged in asking the researcher questions in a 'point-counterpoint' style, reminiscent of an active dialogue. Hence, this eventual initial discomfort did not seemingly affect the whole interview; it was apparently overcome.

Greater nervousness was observed more often with younger participants, principally when discussing the connection between CBT and ET. Older participants appeared to speak more freely and confidently about it. The effect of this was that, in the case of the younger participants, there was a greater need for the researcher to draw out descriptive scattered information.

As detailed in the previous chapter, the eight interviews were conducted with practicing and accredited British CBT therapists. They worked in diverse settings, including IAPT,

private practice, and secondary care, and their years of professional experience were wide ranged. This variety is recommended in qualitative studies utilising IPA.

Some demographic differences regarding how each framework was conceptualised, valued, and utilised emerged. Namely, as previously mentioned, age appeared as a catalyst of learning and reflection about one's own abilities and preferences across distinctive frameworks. In terms of gender differences, women practitioners framed their incorporation of tools-in-lack in their personal as much as their professional roles. A similar observation has been made elsewhere (Artkoski & Saarnio, 2012; Jome & Murray, 2012). Secondly, women apparently valued structure less than men, discussed more often than men the link between body and mind, and valued more the inherent intersectionality of an approach such as ET. Nevertheless, since the majority of participants in this study were men and the comparison between genders and age cohorts was not systematic or an aim of the present study, these group comparison conclusions and their implications for practice require further exploration.

As a process of data analysis, IPA allowed not only for the narratives of the eight participants to be the focal point of the research, but also for the lessons learned from their experiences to come to the forefront of the discussions. As per the interviewer, rather than offering a simple description of participants' experiences, IPA seemed to allow for a deeper, more introspective, understanding of participants' practice and the challenges they encountered in integrating different therapeutic modalities. Kay and Kingston (2002) offered a similar remark, when claiming that IPA could help researchers to become intimately familiar with the ideas, beliefs, and behaviours of those whom they seek to understand better.

IPA is more concerned with characterising in-depth the experience of particular people in particular circumstances than with generalising findings to other people. This helps to have a sense of various ways in which certain events, in this case integration, are experienced. Nevertheless, IPA can also serve to gain insight into narrative patterns, i.e., experiences and meanings that are, as expressed, shared by several participants. These more recurrent viewpoints aid in setting the context for an adequate discussion of findings and in providing a broader understanding of the phenomena under scrutiny (Smith, et al., 2009). These more generalied understandings grounded a great part of findings' description and discussion.

Although beneficial for methods such as IPA, the small number of participants always raises the question of the representativeness of the data. For instance, findings were greatly concerned with the working environment of British therapists; cross-country variation can be expected. Findings helped to have a sense of how specifically British therapists perceived, and may perceive each approach, what drove, or may drive integrative practices, and what pitfalls were, or may be, associated with both approaches and their integration. Yet, many issues remained unaddressed and further studies are required. Examples include whether and how therapists may coordinate a flexible attitude with a structured attitude, and how and whether tools-in-lack can help to devise better integrative frameworks.

Participants in this study did not address the particular issues faced by clients with language barriers or learning disabilities within the structured model of CBT, as this is seen to be less effective with these populations (Butler et al., 2006). It was simply reported that it was important to adapt the treatment to each client. Future research examining the specific needs of this group of clients and the approaches used by therapists to address

the broader contexts in which they are treated would be a useful addition to the literature on integrating therapeutic modalities.

Finally, an important finding in this study is that some therapists, and principally younger ones, may lack the training that allows them to reflect upon and integrate modalities. A previous study involving newly qualified mental health nurses (Rungapadiachy, Madill, & Gough, 2006) found that in the early phases of working as qualified professionals, participants reported a lack of confidence in using some techniques, feeling that they lacked adequate supervision and were, to some extent, overwhelmed by the disparity between the theory they had learned in training and the reality of dealing with mental health clients in practice.

In a similar vein, it is quite likely that clinical therapists must build some experience of understanding ways to address different client needs before they feel sufficiently confident to move beyond the manual of techniques and structured approach of CBT. The content and structure of the training needed for practicing integration, as it refers to things other than the philosophical origins and practices associated with different modalities, remains however unclear.

7.8 Self-reflection

Interviewing mental health practitioners, whether they are psychologists, counsellors, psychoanalysts or the like, is arguably a rarity compared to those clinicians' routine of interviewing and evaluating their clients. In this study, there was no psychometric evaluation of participants, a departure of a standard element of practice that the participants were used to, particularly when first establishing a therapeutic relationship.

Consequently, the mere act of engaging clinicians in a professional activity that they typically perform themselves (interviewing) was likely a departure from their typical routine. That is worth noting because the participants, to varying extents, were initially taken out of their element. This, coupled with the various settings in which the study participants were interviewed, added a different element of examination that is not the norm for such practitioners, and can be perceived as leading to the revelation of certain mannerisms and assertions by participants that otherwise would routinely stem from their clients (Yalom, 2002).

In this manner, this methodology allowed for participants to examine themselves in a mirror whilst the researcher was able to do the same, enabling an introspective assessment on both sides. Such a methodological approach allowed for the researcher as well as participants to experience the meaning behind Krug's words: "*we are all in this together and there is no therapist and no person immune to the inherent tragedies of existence*" (Yalom, 2002, p. 8).

Furthermore, in the interview approach, whilst there is still a respect and profound belief in the interpretation of events offered by participants, there is also an acknowledgement that participants can expand upon their narratives by changing storytelling contexts (physical spaces, public, circumstances, etc.). Irrespective of the survey or interview approach, IPA intends to engage in the delicate process of spectating rather than directing the manner in which participants reveal themselves. In this manner, IPA is inextricably linked with more of a philosophical than scientific disposition (Englander, 2012). It also means that the method is appropriate for the present study because, in the act of

spectating, one can focus on describing and interpreting relevant data, and thereby fulfil one of this study' aims.

Rather than remaining detached, it is incumbent that researchers are greatly involved in participants' personal worlds (Hein & Austin, 2001). To achieve this, IPA demands a heightened state of consciousness on the part of the researcher (Englander, 2012). However, in order to prevent researcher bias from unduly burdening or tainting the analysis, researchers must also be mindful to be both interpretative and grounded. Therefore, although perhaps difficult to accomplish perfectly, interpretation must be descriptive and let the data stand on its own without needing to be explained through a researcher's lens. It is thus the difficult task of the IPA researcher to be part guide, part mirror, and part scribe (Denzin, 1995). When occupied with these tasks, there is little room left for the researcher or the participant to be judgmental. That stated, such an exercise was catalytic for a deeper understanding of what it means to take stock of something phenomenal In particular, the use of in depth interviews as data gathering enabled - indeed, necessitated - the mirroring, eliciting and scribing functions of the IPA researcher to be harnessed.

The lead researcher of the present study came to the profession by way of the business field and did not often have reflective experiences about the self in the professional setting. This was partly due to the innate and understandable focus of psychotherapy on one's clients. That said, such reflection is beneficial for counselling clients since it helps practitioners regularly to ground themselves and have more to offer than theory alone, such as appropriate companionship in understanding the joys and tribulations of life - both an

integrated and unified way of thinking, reflecting, and relating in the therapeutic environment.

Chapter 8 – Discussion of Findings

Two studies were conducted for this thesis: a mixed-method study, or 'mixed' strand, for abbreviation purposes; and a qualitative investigation, or 'qualitative strand', equally for abbreviation purposes. In the mixed strand, the opinions of two hundred and fifty-three BABCP members, regarding CBTs, ETs and their existentialism-based integrative practices, were gathered via an online survey. In the qualitative strand', face-to-face interviews were conducted. Their aim was to explore the in-depth opinions of eight BABCP members about the same topics. Jointly, the two research strands aimed to:

1. explore the therapists' level of satisfaction with CBT;
2. test whether decreases in satisfaction with CBT were related to increases in 'existential thinking'; and
3. explore therapists' views, experiences, and ways of incorporating existential therapeutic components within their CBT practices.

Of the aims outlined above, the first two were answered primarily via the 'mixed' strand, whereas the last was addressed mainly via the qualitative strand. Yet, as previously discussed, both strands helped to clarify each one of these aims. The conduction of quantitative and qualitative studies about the same aims is even a recommended, trustworthiness-enhancing research procedure, which helped to triangulate the mix strand findings (Bryman, 2006; Creswell, 2013; Creswell & Clark, 2018; Mertens, 2009; Morrow, 2005). Hence, albeit in different manners, and as it will be detailed in the following sections, both investigations could, and actually were illuminating about the above aims.

Main findings will be discussed in the following subsections. Additionally, the limitations of the study and future research suggestions will be offered.

8.1 Satisfaction and dissatisfaction with CBT

Findings from the two strands suggested that CBT therapists were generally highly satisfied with CBT. For instance, as illustrated in Figure 1, in section 4.2.1, 81% of the survey participants expressed their satisfaction with CBT by agreeing or strongly agreeing with the item 'Overall, I am satisfied with the use of CBT with my patients'. Yet, simultaneously, this finding implies that 19% of therapists were not quite satisfied with CBT. Hence, this research seems to have posed an understudied, but relevant question; most, but not every CBT therapist was satisfied, not even moderately, with the therapeutic method they were using. A similar opinion was voiced in the qualitative strand.

8.2 Satisfaction and criticism of CBT

Named reasons behind clinicians' dissatisfaction with CBT were explored in both strands. For one, as illustrated by Figure 1, in section 4.2.1, survey results indicated three main sources of discontentment: number of 'tools'; scope of treatable presenting issues; and the adequacy for discussing big issues. Participants agreeing and strongly agreeing (ratings of 4 and 5) that CBT was satisfactory in these circumstances were, per item, respectively, 42%; 32%; and 28%. In each one of these cases, the majority of clinicians was not satisfied with CBT, or, at best, felt rather neutral about its benefits.

Moreover, as discussed in the previous section, the were 81% of generally satisfied clinicians, which is a proportion higher than the proportion of therapists arguing CBT could be utilized in every circumstance, and enabled them to address big issues, highlighted in the preceding paragraph. This was suggestive that clinicians' recognition of CBT's limitations did not necessarily generate dissatisfaction; the two opinions coexisted in some instances. That is, the survey apparently quantified a state of, if not emotionally, surely cognitive 'ambivalence', defined as the non-clinical state of experiencing simultaneously positively and negatively valenced opinions and emotions, of varying degrees of emotional intensity, toward some 'object' (Ashforth, Rogers, Pratt, & Pradies, 2014), in this case, CBT.

These findings then supported Sanders and Bennett-Levy (2010, p.457) recognition that most therapists would likely have come across, during their professional practices, both the weaknesses and the strengths of CBT:

> Early in your cognitive behavioural therapy (CBT) career you will, hopefully, have come across many examples of ways in which CBT can make a difference. You will also be getting a good idea of the limitations of the approach, people whom CBT does and does not suit, and times and situations where the methods are or are not applicable.

This very same 'ambivalence' was discussed in Chapter 1, such as when exploring authors who, along with Gebler, and Maercker (2014, p.156), were of the opinion that CBT was "*not enough*". Indeed, as discussed in *Chapter 1*, anyone working for the purpose of integrating CBT with other modalities expresses cognitive ambivalence. It attributes value and flaws to each one of the integrated modalities, inclusively CBT.

Qualitative strand participants also seemed to implicitly voice this ambivalence. For example, Robert noted that CBT *"sometimes [is] all that's needed*". Thus, he seemed to be implicitly acknowledging CBT was *sometimes* adequate, and *sometimes* inadequate, or insufficient. This seemed to illustrate clearly the aforementioned state of cognitive ambivalence. As Robert, most qualitative study participants felt CBT lacked tools, could not be used to address every presenting issue and was not suitable for addressing big issues. In John's case, this recognition generated what was described as "*a huge sense of frustration with"* CBT, as defined by IAPT, and triggered the desire to use tools from alternative modalities.

In sum, in both strands of research, and on a canvas of liking the modality that one has oneself chosen and wishes to apply, criticism and dissatisfaction were expressed, inclusively by the very same person. Thus, findings from the present research provide empirical support to the discussions help in *Chapter 1*. Any person pursuing the development and use of integrative approaches must simultaneously be pleased and displeased by the modalities being integrated with one another.

8.3 CBTs' weaknesses in the light of qualitative findings

As discussed in the preceding section, the limitations or weaknesses of CBT were quantified in surveys as relating to CBT's lack of tools, inability to address every presenting issue, and inability to address big issues. These findings thus supported the discussion in *Chapter 1,* which explored how CBT was not necessarily superior to other modalities (e.g., Cuijpers et al., 2013; Tolin, 2010), was inadequate for certain presentations (Gaudiano, 2008; Gebler, & Maercker, 2014;

Rhodes & Jakes, 2009; Zettle & Hayes, 1987), and was unable to address the spiritual concerns of spiritually inclined clients, even when they so desire or need (e.g., Gebler, & Maercker, 2014; Prasko, Mainerova, Jelenova, Kamaradova, & Sigmundova, 2012; Zoellner & Maercker, 2006). These were some of the aspects which were identified as eventually partly responsible for the low to moderate efficacy of CBT (Cuijpers, Berking, Andersson, Quigley, Kleiboer, & Dobson, 2013; Paley, Cahill, Barkham, Shapiro, Jones, Patrick, & Reid; 2008; Stefan, Cristea, Szentagotai Tatar, & David, 2019; Stiles, Hill, & Elliott, 2015; Stiles, Barkham, Mellor-Clark, & Connell, 2008; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006; Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997).

In the qualitative strand, interviewees also expressed the weaknesses of CBT. Simultaneously, participants also identified some of the missing elements of existentialism, albeit less extensively. This unevenness possibly indicated some bias, with discussions about the flaws of CBT being instigated more than those about the flaws of ET. This should be bore in mind, when taking in the findings detailed here.

Namely, the limitations of CBT were illustrated by two higher-order themes, ‘missing elements’ and ‘assertion of the human’, detailed in Table 23, section 6.1. Their subthemes showed interviewees discussed modalities in apparently polarized terms. These themes showed ‘CBT’ was criticized for being too superficial and structured, for ignoring clients’ preferences and therapists’ difficulties, for creating a hierarchical power dynamics, and for offering to clients more support to the exploration of their lives from an intellectual and individualistic standpoint, than from emotional, spiritual, situated, and social perspectives.

CBT was further criticized for lacking in humanity and authenticity, disregarding discussions about the 'meaning of life', among other very diverse theoretical and practical issues. For example, John complained that CBT did not allow him to explore the relationship between clients' cognitions and the world at large. As remarked, under CBT, "*the origin of why they might infer a certain something about the world was never open for exploration*". This possibility was however fundamental. As Joanne noted, *"you can't work with a person in isolation 'cause we don't live in isolation*."

Additionally, when Karen described her cognitive-behavioural work with PTSD clients, she stated that *"when it comes to the emotional reaction (…) that's what CBT can't work on that deep level, which has sometimes come from childhood."* That is, for Karen, CBT was not prepared to deal with "*irrational*" (Karen) and emotional issues, and inclusively on their historical aetiology. Finally, when Joanne commented that it "*is those bigger questions of sort of why are you here, what do you think your purpose in life is",* she clearly denounced how Frankl's (1959/ 2017) existentialist stance was missing from CBTs.

In sum, according to interviewed practitioners, CBT did not offer the tools to explore these non-individualistic, non-contextualized, less logical 'issues' alongside clients. Yet, for some clinicians, this was a pretty significant lack, for, as Mark acknowledged "*there's no point working on choices when [laughingly] there is no choice*".

These findings support the discussions held in *Chapter 1*, which explored how 'CBT' had been criticized for being too 'mechanist' and directive, disregarding many aspects of clients' experience and their volition (Gaudiano, 2008; Freeman & Garety, 2004; Rhodes & Jakes, 2009; Seligman, 1995), along with many aspects of clients' place in the world,

including gender, coping skills, age, ethnicity, etc. (Crews, & Harrison, 1995; Gabbard, & Ogden, 2009; Seligman, 1995).

Qualitative findings also corroborated the observation that there are benefits of taking onboard client's beliefs and values during the course of therapy, as previously empirically found (Chambless & Ollendeck, 2001; Frueh, Cusack, Grubaugh, Sauvageot, & Wells, 2006; Hodge & Lietz, 2014; Khoury et al., 2013), and of addressing deeper issues, such as the meaning of life (Mearns, 2003). Changing distorted cognitions may be insufficient, and does not necessarily bring about psychotherapeutic benefits (Gaudiano, 2008; Parker, Roy, & Eyers, 2003; Zettle & Hayes, 1987). Moreover, as detected in previous findings, intervening at an emotional level is apparently and empirically more important than intervening at a cognitive level (Parker, Roy, & Eyers, 2003; Teasdale et al., 2001; Teasdale, 1999), or that behavioural interventions often suffice (Gaudiano, 2008). Eventually, to an extreme, "*no additive benefit to providing cognitive interventions in cognitive therapy*" (Zettle & Hayes, 1987) is found.

8.4 Satisfaction with CBT and existentialist thinking and practices

This study investigated whether there was a positive correlation between existentialist thinking, as measured by the composite score of SET, and satisfaction with CBT, as measured by the composite score of CBT-S. Findings supported the null hypothesis, which posits there is no correlation between the variables. Yet, doubts about this conclusion were raised when inspecting cross-scale, inter-item correlations.

Specifically, some support for the initial hypothesis was revealed by the statistically significant but weak trend in the cross-scale inter-item correlations in section 5.3.7. From these correlations, it will be brought to discussion two of the items of CBT-S, one assessing participants' overall satisfaction with CBT and, the other, evaluating their contentment with the tools CBT had to offer. As illustrated in highlighted in red in Tables 9 and 10, these items, which can be taken as measures of satisfaction, showed negative, significant but low correlations with items of the existentialist thinking (SET scale, Table 10) and items of ETs (CBT-E, Table 9). This meant that the higher their 'satisfaction' was, the less their thinking and practices favoured specific existentialist views.

For example, the item 'overall satisfaction with CBT' generated negative, weak but significant correlations with items of the SET and CBT-E scales, including 'I believe existential themes are a vital (…)' (CBT-E scale) and 'Do you ever reflect on your purpose in life?' (SET scale). Thus, participants who were less satisfied with CBT in general did show higher propensity to professionally assign value to existentialism and to personally employ one of its tools personally.

Simultaneously, the inter-tem and significant correlations in Table 11, illustrative of correlations between SET and CBT-E, were all positive, suggesting that those who were personally inclined to think personally about existentialist issues were generally more inclined to favour and use ETs' tools.

In sum, knowledge and/or experience with ETs seemed to come hand in hand with integrative practices, both of which indicative of slightly lower satisfaction with CBT. In the qualitative strand, findings indicated similarly that those who were interested in ETs

personally more often integrated ET into their CBT practices. For example, Ann discussed how her turn towards phenomenological clinical practices was instigated by the use of ETs in her life - and not by any type of professional training:

> *As time went on, I actually realised how important … some of the ideas that I was actually using … with myself (…), and I suppose it was really in my study in a way that in roundabout way came back to the existential idea using kind of the phenomena with images, and that's how I came across, kind of, phenomenology.*

In the light of qualitative findings, the relationship between lower satisfaction and integrative practices appeared to be enhanced by the institutional pressure for the use of CBT-as-IAPT formulations. As Joanne commented:

> *I think that [working within an IAPT context] helped to solidify my ideas about the need for holistic approach to CBT because the IAPT is a very diluted, especially the lower intensity self-help, manualised.*

Similarly, Mark confessed that CBT:

> *become mechanistic, it's become very much issue-focused as opposed to client focused… and I think the worst thing that's happened to CBT is that it's got linked in far too closely with politics and the NHS…*

That is, the relationship between respondents' dissatisfaction with CBT and their existential thinking seemed to be more pronounced for those who were thinking about

CBT-as-IAPT. This echoed what had already been noted in the analysis of open-ended mixed strand questions, where for example someone had remarked that "*particularly CBT and Existential Therapy - asking about meanings is central to either approach in my opinion.*"

This is in line with the discussion held in *Chapter 1*, where it was noted that CBT-as-REBT, unlike, say, CBT-as-IAPT or CBT-as-BT, seeks to "*help clients make a profound philosophic change that will affect their future as well as their present emotions and behaviors*" (Ellis, 1980, p.326) and was acknowledged to have been greatly affected by ETs and phenomenology. These influences can be noted particularly in the Way Ellis regards human beings as "*philosophers (Ellis, 1962, 1973a) and (…) creators of meaning (Frankl, 1966)*" (Ellis, 1980, p.326) and instigates clients to exercise forward-looking in ways that evoke Frankl's logotherapy.

In conclusion, the more granular (item-related) and the broader (composite scores related) conclusions of the mixed strand yielded contradictory conclusions. Yet, both the qualitative and the mixed strands offered some evidence illustrative of how lower satisfaction with CBT, and principally with CBT-as-IAPT, was associated with a personal and clinical inclination to use ETs practices. Given that no other empirical investigation about the relation between satisfaction with CBT and existentialist thinking and practices in practicing CBT clinicians has been found for the purpose of this discussion, this topic, and the initial hypothesis, merit further future investigation.

8.5.1 The popularity of integrative practices

Presently, "*the use of specific techniques by practicing therapists is thought to be an understudied area* (Thoma, & Cecero, 2009,p406) Nevertheless, investigating the techniques employed by practicing counsellors could help to understand whether therapists adhere in practice to a single modality ('pure practitioners'), utilize techniques from other modalities ('non-pure practitioners'), and the prevalence of available modalities. Thus, this study simultaneously helps to address this gap and has little benchmarks to which its findings can be compared to.

So as to open way to this line of investigation - and one which, as a side-effect, creates doubts about the validity of RCTs, as discussed in *Chapter 1* - some of findings of the present study will be discussed here, as these refer to surveyed CBT psychotherapists.

Firstly, in the mixed strand, the structure of the survey, and thereby conclusions, cannot affirm validly the prevalence of CBT psychotherapists integrating ETs in their practices. Not only there was no item inquiring directly whether they integrated ETs and CBTs in their practices, as the terms CBTs and ETs were not operationalized for respondents and hold validity issues that will be explored in more detail subsequently.

Nevertheless, the mixed strand clarified, as per the CBT-S scale results for ratings above four (illustrated by Figure 1, section 5.3.1, item 'I integrate other approaches'), that 64% of survey participants integrated non-CBT (possibly but not necessarily as inclusive of ET-related) techniques into their practices. Those who integrated often non-CBT techniques into their practices can be regarded as therapists who felt they were non-pure CBT therapists. That is, these were 'integrative' (eclectic or otherwise, see *Chapter 1* for

considerations about the construct 'integration') clinicians. Additionally, only 21% 'strongly disagreed' or 'disagreed' that they integrated other modalities into their practices; these were pure-CBT therapists. The 16% with neutral ratings cannot be associated with either pure of non-pure CBT practices.

These results illustrated how the majority of mixed strand respondents felt that theirs were non-pure practices.

As for the qualitative strand, due to sample selection procedures, none of the interviewed CBT clinicians could be regarded as a 'pure-CBT' practitioner. These results are in accordance with what has been declared as "*the zeitgeist of the new millennium*" (Aafjes-van Doorn, Klinar Alfaro, Fialová, & Kamsteeg, 2018, p.506) or the 'trend' (Gelso, 2011) in psychotherapy. That is, "*it would seem that the days when it was seen as nearly sinful to draw from different theories, even while maintaining a primary approach, are thankfully gone*" (Gelso, 2011, p.184).

Note that the adjective 'thankfully' is demonstrative but of a personal preference for integrative practices, even when acknowledging that "*there is no solid empirical evidence that integrative treatments are superior to single-theory treatments*" (Gelso, 2011, p.184) and in the absence of solid prevalence studies of clinicians' practices (Thoma, & Cecero, 2009).

This absence of investigations concerned with the practices of psychotherapists is apparently more pronounced for British counsellors (Hollanders, & McLeod, 1999), as compared North American counsellors (Cook et al., 2010; Michalski, Mulvey, & Kohout,

2010). As found, in 13% counsellors utilized 'pure' modalities, CBT or else (Hollanders, & McLeod, 1999). Everyone else was a non-pure practitioner. Thus, both the present and Hollanders, and McLeod's (1999) findings support Gelso's claim regarding the popularity of integrative practices as long back as 1999 and in the United Kingdom. However, no conclusions can be validly drawn regarding increases in prevalence; their 'trending'.

8.5.2 Are integrative practices really trending?

As noted, the practices of North American counsellors have been more extensively studied. The study where the greatest prevalence of non-pure practitioners was found for the purpose of this review was Cook et al.'s (2010) study of 2739 North American responding clinicians. It showed that most endorsed CBT, but only a minority of 2% used a single modality in their practices. This showed that most practitioners, including CBT therapists, were non-pure practitioners. These non-pure practitioners are often described have exercising integrative stances in a broad sense (see *Chapter 1* for a discussion of the many forms of exercising integration).

Cook et al.'s findings thus indicated that the prevalence of non-pure practitioners in the U.S. not only 'rivalled with' (Norcross, Karpiak, & Santoro, 2005) the prevalence of pure, mono-modality psychotherapists, as it clearly surpassed it. Yet, as noted, this was the greatest nation-specific prevalence of integrative practices found for the purpose of this review, even when limiting the search to the U.S. For example, in Michalski, Mulvey, and Kohout (2010, Table 15), from a total of 5051 North American APA and non-APA members, there were, as self-proclaimed. 14.6% (vs. Cook et al.'s 98%) with 'integrative' orientations. To this value one could add, depending on one's definition of integration,

those many, from an unquantified total of 6% who, choosing the 'other' option, identified 'eclectic orientations'. In this manner, these prevalence results of integrative practices would be closer to the prevalence found for the present and Hollanders, and McLeod's (1999) studies for the case of British clinicians.

Michalski, Mulvey, and Kohout's (2010) reporting procedure regarding eclectic practices further showed how some respondents, and eventually the authors, felt the need to report under the other option, and not in the integration option, their eclectic practices. Hence, they interpreted their eclectic stances as something which was not properly classified under the offered option 'integration'. Since other participants may have made a different decision when it came to their integrative practices, there may be some construct validity and reliability issues regarding the term integration in their study.

Indeed, part of the variation in the prevalence of pure and non-pure practitioners here illustrated has been attributed to differences in the way 'integration' is operationalized (Rihacek, & Roubal, 2017). It is argued here that these construct validity issues are partly driven from the frequent absence of formal training in integrative practices in non-pure practitioners. As it has been proposed, "*for some practitioners, psychotherapy integration may be a natural and unintended consequence of ongoing professional development, behind the practices of most non-pure practitioner*s." (Aafjes-van Doorn, Klinar Alfaro, Fialová, & Kamsteeg, 2018, p.506).

In the qualitative strand, some interviewees did describe a 'natural', interest-driven professional development path to their non-pure CBT practices. An example was Joanne, when claiming that "*I haven't trained in existential therapy and you know you pick up*

bits here and there and from different people." Another example was offered by Stuart, when noting that*:*

> *You're supposed to set an agenda with CBT. I've very rarely been able to do that (...) because (...) they start as they come in the door and then they're starting to talk about what their concerns are and I'm not CBT enough to say "Well, never mind all that stuff, what you were referred for is this, so what we're going to talk about is that.*

Even if clinicians wanted to be trained in 'integrative therapy', this is not often a modality or modality-choosing process that is being taught, assessed, and disseminated in institutions providing mental health services and training, worldwide and in the U.K. (Aafjes-van Doorn, Klinar Alfaro, Fialová, & Kamsteeg, 2018). The IAPT framework, adopted by the NHS, has also been said to *not* offer, to trainee therapists, theoretical and philosophical knowledge of the origins of diverse modalities (Lewis, 2012; Milne et al., 2010; Nanda, 2010; Wong, 2012) and the skills required to integrate different modalities (Beidas, Edmunds, Marcus, & Kendall, 2012; Green, Barkham, Kellet, & Saxon, 2014). This has been said to hinder the therapists' ability and willingness to integrate approaches in any meaningful way (Wong, 2012) and can lead those in need of such support to avoid therapy in the long run (Oliveira, Sousa, & Pires, 2012).

Some of these studies' findings support these observations. For example, mixed strand findings indicated that there apparently was a relationship between having been trained in alternative modalities and integrating that modality in one's practice. As it applies to ETs and other meaning based approaches, the cross-scale inter-item correlations in Table 9, section 5.3.7, indicated that being trained or versed in 'ETs', as measured by item 22 of CBT-E, was significantly but weakly related to freely adapting CBT techniques and to

adhering to integrative practices. Additionally, responses to open-ended survey questions discussed in *Chapter 5*, and identified in Tables 18, 20 and 23, suggested that some CBT therapists felt they needed more training to be able to integrate ETs into their practices. For example, one respondent remarked "*I would consider integrating existential themes into my CBT practice but frankly, without further training and supervision to guide me, I wouldn't know where to start*."

For the qualitative strand, as explored for the subtheme 'personal and professional background', there was also some minor indication that participants' training, eventually informal and spontaneously conducted for professional development purposes, helped them to integrate modalities. For example, Graham recognized that:

> *when I first started reading Yalom and van Deurzen and all those others, it was a real light bulb moment for me (…). I think that once that light bulb has come on it does change what they [clients] do, I think it's very important and not just weaving it in with CBT.*

Graham described what appeared to be a natural interest-driven career development path to his current non-pure psychotherapeutic practices; he tried to help clients to experience as he had the benefits of embracing ETs.

In sum, there was some evidence that being interested and trained, either informally and/or formally, in a modality facilitated the 'informal' ET-based integrative practices of non-pure CBT psychotherapists, as it has been suggested in the literature and has been discussed previously from a policy perspective (Sausman, Oborn, & Barret, 2015). These results further are in accordance with Cook, Biyanova, and Coyne's (2009) qualitative

study of the barriers experienced by North American psychotherapists to the adoption of new treatments, among which training could be found.

In conclusion, this section exposed how the found disparate prevalence rates of integrative practices were affected by the way integration was defined in different studies and/or how respondents understood the term. Given the non-abundant offer of formal training programs on integrative practices, replies confessing to exercise integration possibly simply clarify whether psychotherapists confess to being pure or non-pure practitioners. These do not clarify about the prevalence of any formal integrative practice that can be validly compared to other pure modalities.

8.5.3 Construct validity issues affecting the labels CBT and ET

In the present study, the CBT-S inquired about psychotherapeutic practices without making use of the term integration. Thus, it simply clarified how many 'self-confessed' non-pure CBT practitioners there were in the sample of responding BAPCP members. Yet, taking detected frequencies as representative and valid would require respondents to share the same notion of what 'pure CBT' was. Otherwise, what one took to be a pure practice, another might take as a non-pure practice.

Findings from this study pointed to such lack of consensus in the way 'CBT' was defined by respondents, and one which undermines the validity of findings. For example, as noted in the open-ended questions of the mixed strand, mindfulness techniques were sometimes regarded as a new CBT therapeutic technique, as when it was noted that "*I did not think CBT would include this, but with the growth of mindfulness based CBT* (…)". In the qualitative strand, Stuart similarly remarked how:

> *CBT does have this sort of tendency, so if it finds something that works it just takes it, tweaks it a bit to put in cognitive element and calls it CBT, and CBT is adopting and moving into things like compassionate mind and imagery work, mindfulness, which are quite a long way from CBT as Beck originally thought about it.*

In the quotes above, participants noted that the definition of CBT had changed and could cover a variety of modalities, including mindfulness-based approaches. Yet, other respondents seemed to stick to a narrower definition of any of these terms. It was also this narrower understanding of CBT that Joanne, in the qualitative strand, associated with IAPT practices: "*I think being part of IAPT for a bit helped me to … say … CBT is a lot broader than this and could be even further broadened*". In the mixed strand, there was also one participant excluding from CBT any application that did not "*stick to the instructions and let the therapy do what it says on the tin.*" Hence, the frequencies detected for the mixed strand may hold construct validity issues, inclusively in the light of qualitative strand results. They also seemed to have affected the aforementioned prevalence studies.

For example, Michalski, Mulvey, and Kohout (2010) found there were practitioners holding, 'as primary theoretical service provision orientations', 'Cognitive/Behavioural orientations' (38.9%), but also 'Cognitive orientations (5.1%) and 'Behavioural orientations' (2.9%). The implication of these surveying and reporting procedures is that it allowed the observation that some respondents did not regard CT as CBT or BT as CBT. Instead, they adhered to either one of these to the exclusion of other modalities, including CBT. Similarly, in Cook et al.'s study, formerly described, it was noted that

they did not count third-wave, acceptance/mindfulness approaches as examples of CBT approaches. Instead, a separate option for this modality was offered to respondents.

Note that here the contentions raised in *Chapter 1* must be once more brought to the forefront of attention. Namely, that there is great diversity in the modalities that presently come along in the literature with the label of 'CBT', from REBT, to CT, BT, MBCT, ACT and IAPT-ruled CBT treatment protocols. For any rigorous person interested in criticizing and improving 'CBT', this diversity:

> *behoves proponents of CBT to specify precisely what approach they are [in italics in the original] advocating and its nuanced dimensions – something that is perhaps very far from happening in IAPT programme with accompanying language of being 'rolled out' and delivered across the UK (Loewenthal, & House, 2010, p.178).*

It is here argued that this state of affairs is relevant way beyond the IAPT procedures mentioned by Loewenthal and House. As discussed in *Chapter 1*, this level of specificity is often lacking, inclusively from empirical investigations and their meta-analyses. One often has to search the whole paper to detect what sort of conception of CBT is being addressed in that paper. Exceptions can of course be found. For example, several authors have specifically investigated CBT-as-CT's claims about the psychotherapeutic benefits of changing distorted cognitions have been investigated, with disappointing results (e.g., Gaudiano, 2008; Parker, Roy, & Eyers, 2003; Zettle & Hayes, 1987).

To an extreme, for respondents and researchers grounded on the state of the art in the early 20th century, CBT would be viewed as an integrative modality in itself. It would

operate at the level of praxis (technically eclectic integration, if you may) and would not resolved the theoretical criticism of BT's founder, Skinner, to the validity of CT. This was perhaps the case of respondents in Michalski, Mulvey, and Kohout's (2010) study who discriminated CT and BT from CBT; in the description of 'integrative treatment approaches' in Aafjes-van Doorn et al.'s (2018) paper, were third-wave modalities can be found; and in Cook et al.'s study, where acceptance and mindfulness approaches were similarly segregated from 'CBT'. For these participants and in these studies, all this variety might represented non-pure CBT practices.

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On the other extreme, there would be those who, grounded on more contemporary uses of the term 'CBT', and just like Stuart, might consider as pure-CBT: the technically eclectic approach incorporating CT and BT, even against Skinner's contentions regarding the scientific validity of CT; the existentialism-informed REBT, even against Ellis' initial opinion; and third-wave modalities that integrate, into an often unspecified modality, a wide varied elements, from meditative-based self-awareness, to acceptance or dialectics, and other 'humanistic' (Gilbert, 2010; McWilliams, 2011) and Buddhist (Hayes, Follete, & Linehan, 2011) elements.

The same perhaps ambiguity can be observed in both the qualitative and quantitative strands of this research for the ambiguous 'ET' (Cooper, 2003/2017; Correia, Cooper, Berdondini, & Correia, 2018; Frankl, 1967; Halling & Nill, 1995; Spinelli, 2006a; 2006b; Stumm, 2005) modality. As quantified in Table 15 of 5.4.1.1, the survey had an open-ended question where participants were asked to describe what they understood 'meaning-based approaches/existential themes'. For instance, one participant remarked "*I have an interest in Yalom's work on death anxiety and anticipatory grief as well, as*

concepts such as transiency and ripping, and find them useful to consider with clients." As discussed in Chapter 1, Yalom founded a well-known ET. Hence, this participant appeared to hold more formal knowledge of ETs.

Yet, as discussed in *Chapter 1*, Yalom's ET focuses on exploring the processes that emerge in the 'here and now' (Krug, 2009; Yalom, 2002), paying close attention to the therapeutic relationship and to the here-and-now ontic experience of clients, inclusively as it relates to ontological issues. It therefore bears some resemblance with Rogers' client-centred, humanistic modality, which is generally regarded as an humanist stance that is eventually being integrated into some third-wave modalities.

Secondly, for the mixed strand, there were also replies equating meaning-based and other ET modalities with the "*use of mindfulness and acceptance in CBT, finding meaning in the midst of distress.*" Yet, as already discussed here, mindfulness is more properly understood as a new, third-wave, possibly 'integrative' CBT technique (Bass, van Nevel, & Swart, 2014; Hayes, Follete, & Linehan, 2011) than as an ET technique. Although there is some resemblance between phenomenological methodologies and mindfulness, in neither theory nor practice are these techniques identical (Harris, 2013).

Secondly, as already discussed in Chapter 1, finding meaning, in an intellectual sense, can be regarded as a CT technique. When the focus is on attitudes, it can be regarded as a REBT technique. Yet, as discussed in *Chapter 1*, not every ET is regarded as meaning-based or 'centered', such as in the classification forged by Cooper and colleagues (Cooper, 2003/2017; Correia, Cooper, Berdondini, & Correia, 2018).

Instead, what is most commonly accepted as a commonality across ETs is their interest in investigating the ontics (or lived experience) and/or the ontology (or the universal structure of the lived experience) of individual subjects (Deurzen, 2014; Gebler, & Maercker, 2014; Spinelli, 2006a; 2006b; Smith, 2013). In that these terms might appear obscure to a CBT practitioner, it was wise to avoid their use in the survey. Yet, by phrasing some questions in terms of ‘‘meaning-based approaches/existential themes’ for the mixed strand, this survey might have fueled respondents’ confusion about what was being asked of them, principally when well versed in ETs.

To complicate the picture, in the qualitative strand, there were those who understood REBT and CT as integrating ETs. As Mark remarked:

> *Well, perhaps the earlier approach of CBT was that it was more of a holistic approach in the sense that it was more aligned to perhaps the existentialist idea of somebody becoming something or it allowed for general change in a client as opposed to specific changes and I think that was much more of a psychotherapeutic approach but it is now, in many cases, lost.*

Another example was offered by Robert acknowledged that “*I can’t honestly say where REBT ends and existential begins. They’re so integrated in my mind… I see REBT as the cognitive therapy.”* This suggested that in Mark and Robert’s view, REBT, CT, ETs and CBTs could not be easily differentiated.

In conclusion, the overall findings illustrated a state of confusion and inconsistency in the use of the labels ‘CBT’, ‘ET’ and their multiple derivations, with for example REBT or

mindfulness being as much as a CBT technique as an ET technique. The same inconsistency had already been noted in Chapter 1, and was further illustrated here for prevalence studies. This state of affairs hinders the contextualization of findings. In he light of the literature, CBT is said to be the most common approach, and 'integration' said to be popular and trending - though in that the terms were simply less used in the past or held narrower meanings, these claims may be meaningless.

8.5.4 Clinical use of ETs by British CBT therapists

The mixed strand helped to understand the attitudes of CBT therapists towards meaning-based and other ET techniques. Yet, none of the survey's items inquired participants about whether they actively integrated ETs in their CBT practices. Instead, the CBT-S inquired whether participants regarded themselves as non-pure CBT practitioners. As discussed, it detected that only about a fifth regarded their practices as pure CBT.

Moreover, the CBT-E, as illustrated by Figure 3, in section 5.3.2, showed that 63% of CBT therapists were receptive to the use of existential approaches; 47% valued ETs professionally; and 44% intended to pursue the integration of CBT and existentialism in the future.

Overall, these findings suggested that about half of respondents were open to the use of non-CBT, ETs-related techniques in their clinical practices. Secondly, SET illustrated how, knowingly or unknowingly of their ETs origins, most therapists delved with existential concerns in their daily lives. This was illustrated in Figure 2, section 5.3.3, where it can be observed that those who rarely or never contemplated existential thoughts

were between 3%, for the use of a philosophy for managing one's life, and 31%, for the thinking about a 'grand plan'.

The only measure of past clinical behaviour involving the use of ET-related techniques for the mixed strand referred to their active attempts to develop their knowledge and skills in this area. According to item 22 of CBT-E, 44% agreed or very strongly agreed to having pursued the development of ETs-related knowledge and skills, and 28% disagreed or strongly disagreed that they had done so. This clarified that 44% of CBT therapists felt they had, and 28% felt they had not a more structured or deeper knowledge of these approaches. Among these, but nine respondents gave themselves to the trouble of clarifying that they would need further training to integrate existential themes into CBT (see Table 23, *Chapter 5)*.

Thus, it can be concluded that the knowledge of mixed strand respondents was less extensive for ET-related techniques than for CBT-related techniques, which, given their main orientation and membership, is a rather self-evident conclusion.

Unlike wise, sample selection procedures for the qualitative strand elected for interviewing CBT practitioners with self-acknowledged greater knowledge of ETs, inclusively at the level of clinical practice. Thus, their answers seem to be more validly revealing of the limits and advantages of either practice and their integration during clinical practice.

For the qualitative strand, findings suggested that interviewees integrated modalities to complement their CBT practices and expand the scope of its application, when CBT was deemed less useful or adequate than an alternative. Respondents thus demonstrated to fall within the 'additive integration' hypothesis discussed in *Chapter 1*. As Joanne expressed,

and very much in line with Gee, Loewenthal, & Cayne's (2011) discussion about the need to address relational and spiritual aspects, she presently used something she coined 'holistic CBT':

> *Just to sort of broaden it out and look at, you know, a person in context in terms of systems and systemic, but also in terms of spirituality and what's important to them and things like that.*

Joanne did not present CBTs disadvantages so much as flaws but as limits to its scope. This tendency was described by Aafjes-van Doorn, Klinar Alfaro, Fialová, and Kamsteeg (2018) as sort of pragmatism that could be observed in most therapists, with varying degrees of knowledge and practice of the techniques borrowed from modalities other than one's main frame of reference.

As it will be explored in the following sections, there were specific limits to the clinical value of CBT that apparently motivated interviewees to integrate ETs into their CBT practices. These are described henceforth as drives to the use of ETs. These covered: personal experience of ETs, embracing 'big issues', building better quality therapeutic relationships, and flexibly adapting to clients' needs.

8.5.5 ETs-CBTs integration drives: Personal experience of ETs

SET and CBT-E showed low to moderate but positive inter-item correlations. This indicated that those who more frequently contemplated existential issues in their daily lives more often assigned value to the professional use of ETs and other meaning-based approaches. The qualitative stand supported this conclusion. Interviewees often made

reference to the link between their initially personal, and thereafter professional use of ETs.

Most of these comments were included in the 'personal and professional background' subtheme of the 'Integration' theme. Amongst these comments, there was Ann's, who confessed that introspecting on her personal use of ETs over time allowed her to recognize and use ETs clinically:

> *As I got a bit older and understood a little bit more, I then realised how I myself use it [existentialism] for myself in my everyday life (…) and I think then you can incorporate that within different types of therapies.*

For Robert, personal experience not only allowed for the recognition of value and professional use of ETs, as it was a requisite for their professional use:

> *You've got to do it yourself and to experience it, and not use it like a technique which you just apply. Existentialism is like that par excellence. It's a way of life. It's my way of life. It's my philosophy of life.*

In sum, there was plenty of qualitative evidence illustrating how being personally engaged with ETs facilitated their use during clinical practice. For some, training and knowledge of any of the utilized approaches was a use requisite.

In the literature, not many studies concerned with the how personal inclinations toward ETs affected the ETs-CBTs integrated practices of psychotherapists. Yet, Shafranske, and Malony (1990) did find evidence indicating that the religious and spiritual inclinations of

therapists affected their attitudes and psychotherapeutic practices (Shafranske, & Malony, 1990).

It seems to be sort of a given, that, given the choice, as in the U.K. (Aafjes-van Doorn, Klinar Alfaro, Fialová, & Kamsteeg, 2018), psychotherapists would opt for psychotherapeutic modalities and techniques that they personally value, principally at the stage of career development. It also seems rather obvious that past personal experience with whatever technique will facilitate its application in clinical practice; that is the objective of any training. Hence, it is unsurprising that both here and in Finnerty (2004), personal experience amounted to a personal drive.

8.5.6 ETs-CBTs integration drives: Avoiding and embracing 'big issues'

Despite the moderate and general openness of mixed strand respondents to the use of ETs, the mixed strand quantified how most practitioners refrained from exploring 'big issues' with their clients. Specifically, 70% of participants confessed to having often guided therapies away from big issues and 72% acknowledged the ineffectiveness of CBTs for addressing these issues. From an existentialist perspective, topics which might be included under the category of 'big issues', are, for example, the way each individual gives meaning to life, death, transcendence, and reality (e.g., Cohen, Mannarino, & Staron, 2006; Loy, 2018).

Some mixed stand clinicians explained their avoidance of these existential issues in the open-ended questions illustrated by Table 20 in Chapter 5. They remarked that these existential issues were at odds with institutional stances, irrelevant "*for the great majority of my clients*", or "'*middle-class*'" issues.

Also as informed by the inter-item correlations discussed previously, interviewees from the qualitative strand would be less likely to avoid existential issues. Indeed, and unlike the aforementioned explanations, their commentary was very much in line with the discussion held in *Chapter 1*. Namely, it illustrated that they felt that it was therapeutically beneficial to embrace these issues during therapy, for which purpose they had turned to the use of ETs, as opposed to the exclusive use of CBTs, in their integrative practices.

As explored for the 'missing elements' theme, every clinician from the qualitative strand explored why they turned to integrative practices in an additive integration hope. Some of these elements were connected with existential issues that many psychotherapists, in their experience, tended to avoid. For example, a discussion of what happens when one dies in therapy was experienced by Graham as a 'taboo' held was by his palliative care peers. As he remarked, "*nobody ever seemed to start that conversation: 'Well, what do you think happens when you die?' It's almost like it's the last great taboo…*"

Graham himself, upon noticing how CBT's focus of pain was not being effective with those in palliative care, remarked how he "*brought in some humanistic ideas to just kind of sit there and contain and hold it. We talked about why he was fearful of death and all of that, so that was where the existential bit came in*."

In brief, mortality and its eventually spiritual facet was an aspect of human's existence that was missing from CBTs psychotherapeutic processes. For Graham, it should be, for the benefit of the client, addressed by turning towards more humanistic approaches such as ETs.

Joanne also described the importance of discussing the taboo, or, as she put it, the "*elephant in the room*" that was clients' spirituality and faith. For her, just as for Graham, avoiding these topics in therapy potentially created an obstacle and/or wasted a psychotherapeutic strength:

> *If somebody has a faith that's totally ignored in the therapy it can be a huge resource. Or it can, you know, be causing difficulties as well either way. So if it's not explored it's that sort of elephant in the room that can be a resource that's not being used, or can be undermining the therapy, or a bit of both*.

These observations provided empirical support for Deurzen (2009) and Schneider's (2008) discussion of the neglect human dilemmas tend to suffer in therapeutic practice. They further referred that was not quite unsuitable for exploring deeper issues (e.g. the meaning of life, in Prasko, Mainerova, Jelenova, Kamaradova, & Sigmundova, 2012a; and the emotional life of clients, in Brown, Ryan, & Creswell, 2007, or an existential dimension, in Gee, Loewenthal, & Cayne, 2011). Support was also conferred to those studies discussed in *Chapter 1* showing that discussing (vs. avoiding) big issues and existential meanings in therapy was eventually, even if only when brought about by clients themselves, clinically relevant and therapeutically beneficial ((Bauereiß, Obermaier, Özünal, & Baumeister, 2018; Breitbart et al, 2010; Park et al., 2019; Vehling & Philipp, 2018; Vos, 2016; Satin et al., 2009; Westman et al., 2006; Lee et al., 2006; Masearo & Rosen, 2005). For some participants, and principally those more versed in ETs and interviewed for the qualitative strand, exploring this spiritual side was therapeutically important in some cases.

8.5.7 ETs-CBTs integration drives: Therapeutic Relationship

In addition to the discussion of big issues and therapists' personal and professional background, qualitative findings revealed several additional drives behind the integration of ETs and CBTs. As organized under the higher-order theme 'integration', these included the therapeutic relationship. These comments were in accordance with the discussions held in *Chapter 1* describing how the therapeutic relationship amounts to what has been described as critical factor of therapeutic success in the literature, and is included in most, if not all common factors models (Goldfried, 2009; Lambert & Barley, 2001; Mulder, Murray, & Rucklidge, 2017; Teyler & Teyler, 2014; Wampold, 2015).

For example, Mark remarked that being able to form a good quality relationship was a professional requisite:

you have to work on relationships, and if you can't form a relationship or if you can't illustrate that you're able to form a good relationship and sustain a mutually helpful relationship, then you don't go any further…

Yet, the observations from this study raised questions about how 'common' or equal is such a factor across modalities. For these participants, different types of rapport could be enacted through different modalities and with different clients. Secondly, the rapport fomented through CBT was not the 'most powerful' type of rapport, principally for certain types of clients. As Karen noted:

I think one of the most important things to me is – and always has been – the therapeutic relationship. I will take a lot longer now getting alongside someone, getting to know them than probably a CBT assessment would allow for. I mean, I

would include that, but I would want to know how the person's thinking, feeling, just making sure that there's a good alliance…

Karen clarified that 'now' she adopted a more time-consuming and holistic approach to understanding clients' experience. She thus suggested that initially she did not do so. She also clarified that CBTs' strategy for building alliance was sort of 'eyes on the target' and superficial or narrow-focused; it was 'assessment-oriented'. For Robert, a more powerful type of relationship was established via a client-centred approach: "*Rogers' core conditions – the genuineness and the importance of rapport. This, to me, is perhaps one of the most powerful ways of engaging a client, if it's possible to do so on that level…"*

Yet, Mark refrained from classifying the type of modality that he employed to establish a therapeutic bond; "*I [laughingly] wouldn't start from there and say "I'm mixing CBT and existential" or "CBT or existential and something else. I mean, you work with a client and the client takes you into places*". It was by listening and following the client that Mark was able "*to get that sort of level of intimacy where the communication is almost at a therapeutic level, which is almost a different level of consciousness."*

In sum, qualitative findings showed that one of the drives to integration was constructing a better quality relationship. This also amounted to one of the drives of integration in Finnerty (2014). It further seemed to suggest that CBT-based relationships as more superficial, assessment-oriented and rushed. Indeed, as discussed in *Chapter 1*, it was but at a later stage of modality development that Beck recommended CT therapists to pay attention to aspects of alliance (e.g., Gebler, & Maercker, 2014), countertransference (Prasko, et al., 2010) and "transference reactions" (Ottens & Hanna, 1998, p.314) for specific diagnoses (e.g., personality disorders; Ottens & Hanna, 1998) and for specific

goals. Yet, under CT. the importance of these relationships is not at the core of CT's theory, philosophical perspective, or practices. It is merely a secondary focus (Clarkson, 2003; Meichenbaum, 2009).

Thus, findings raised questions about the validity of studies which do not take different types of relationship into account, and particularly common factor models that take that the variable 'therapeutic relationship' is the same regardless of modality, therapist and client. Nevertheless, findings left unanswered the question whether there was an alternative better model for constructing better relationships. Instead, interviewees made references to humanistic, existential and client-centered modes of relating and clients' preferences as factors behind the formation of better quality relationships.

8.5.8 ETs-CBTs integration drives: Flexibly adapting to clients' needs, as these change over time

About a third of survey participants suggested that CBT was unable to address the needs of every client. As some of survey participants further highlighted, in open-ended questions, the decision of whether psychotherapists should employ a modality other than CBT should be client-centered (see Table 19 in Chapter5) . That is, in some circumstances, existential themes could not be ignored or enhanced self-reflection. Additionally, CBTs were not very useful in bereavement or trauma cases, for certain client types, and, as discussed previously in the light of qualitative strand findings, for fomenting the therapeutic relationship**.**

Interviewees from the qualitative strand reinforced this conclusion. As organized under the 'unsystematic nature of integration' subtheme of the 'integration' theme, one of the

drives behind integrative efforts was addressing the needs identified in the subtheme 'client presentation and preferences' of the 'assertion of the human theme'. Some of these needs required therapists to be psychotherapeutic flexibility, by shaping specific CBT techniques to diverse clients but also eventually by making use of techniques offered by alternative modalities. As Karen so clearly expressed:

> *I don't stick to a model. One day a client might come in and they might be feeling really down, and it might be something that they just want to talk about, do you know what I mean? So you can't, you know, you have to be responsive.*

That is, as Mark referred, "*keeping that fluidity in approach and also that capacity to be able to flex and to bring in new ways*" was key for the success of therapy. For Mark, CBT was less useful when:

> *the issue is something that cannot be fixed - it's not going to be fixed, either because it's really just sort of too hardwired, like a sort of personality disorder, or it's a terminal illness, or it's a bereavement, or it's something which is totally out of anyone's control and therefore they don't have any choice about it. There's no point working on choices when [laughingly] there is no choice.*

Hence, in the light of qualitative and mixed strand results, CBTs fell short in several moments (e.g., actively listening to existential concerns), for certain patients (e.g., bereaved clients) and for certain purposes (e.g., building good quality therapeutic

relationship). Yet, this simultaneously implied that, in several moments, for certain purposes and/or for certain clients, ETs were also less useful. For example, for Ann, ETs were less useful:

> *with depression. Existentialism, it takes a very long time, I find, from when I've worked purely existentialism it takes a very long time to move anything. I think then you can lose the person in a way.*

Similarly, for the mixed strand, one participant noted that:

> *Clients tend to request symptom relief and want specific tools and techniques to address this. They actively request a therapy that is different to counselling, a 'doing' therapy. They seem to like the concept of structure and action to tackle their problems.*

In sum, the qualitative strand suggested that "*flexibly tailoring techniques to clients' needs*" (Thoma, & Cecero, 2009, p.406), whether or not part of the initial CBT agenda, and eventually through the use of alternative approaches, was of vital importance for the success of psychotherapy, and one of the drives of integrative efforts. Although differently unpacked here, this was also in Finnerty (2014).

Their answers thus provided support to those electing the flexible adaptation of techniques to clients as a critical factors behind therapeutic success and tangible outcomes (Donovan, Kadden, DiClemente, & Carroll, 2002; Gabel, 2013; Millon & Grossman, 2012; Vos, Craig, & Cooper, 2015) that less frequently possible from within CBTs

frameworks (e.g., Leahy & Holland, 2000; Storch, Mariaskin, & Murphy, 2009).). They further clarified that, as is, CBTs do not enable psychotherapists to address the scope of situations that psychotherapists come across – in which case they eventually turn to alternative modalities.

8.6 Resistance to integrative approaches

Qualitative findings from both strands revealed that there were drives to the use of ETs in clinical CBT practices. Any drive can be regarded as an obstacle, as its absence might deter psychotherapists from integrating approaches. Yet, there were issues that were presented by participants from both strands more as obstacles, doubts or hesitations to their integrative practices.

Some of these resistances', detected via the mixed strand, were systematized in Table 20, *Chapter 5*. According to respondents, the issues preventing them from integrating into their CBT practices meaning-based and other existentialist practices were: lack of training in these modalities (a factor that has been briefly explored previously in this chapter, both in terms of training and of personal experience); perceived incompatibility between modalities (an issue which did not deter those who believed in the additive integration hypothesis unpacked in *Chapter 1* and qualitative strand interviewees); lack of institutional support; and not dealing with clients in need of ETs (an issue explored by the 'client presentation and preferences' in the qualitative strand, and in this chapter, as it related to the flexibilization of approaches).

As the information provided in between parenthesis above suggests, the lack of institutional support was the theme that was less discussed in this chapter. Yet, in the qualitative strand, the subtheme 'the wounded therapist' explored many personal and

social obstacles to the use of CBTs, ETs and integrative approaches, and inclusively the lack of institutional support. Such lack can be regarded as a 'social resistance' (Aafjes-van Doorn, Klinar Alfaro, Fialová, & Kamsteeg, 2018; Consoli, & Jester, 2005) to the use of off-mainstream or less evidence-based practices, principally when practicing in state-funded mental health institutions.

This social resistance was described for both strands. For example, in the mixed strand, one participant claimed feeling *"institutional hostility to using approaches that are not in the NICE guidelines."* Graham also commented on such resistance, though under a more explanative *tone:*

> *As the NICE funding, if you like, is based upon measurable outcomes, that is why they felt they could only recommend CBT and EMD (…). It is organizationally seen as a much safer approach.*

That is, institutions exercising some form of social resistance are formed by individuals and generally express the individual concerns of groups of individuals. Differently said, a social resistance is generally founded on concerns of individuals. Thus, there likely are practitioners who refrain from using less evidence-based techniques and modalities.

As discussed in *Chapter 1*, and acknowledged by respondents, most evidence-based practices consist of CBT techniques, which, from their BT (e.g., Baars, 2003; Watson, 1913) and CT (e.g., Beck, 1961) original beginnings, were developed with 'scientific proof of worth' worries in mind. Thus, when psychotherapists employ non-institutionally approved or less evidence-based techniques, themselves, their peers and their employing

organizations may disapprove and thereby exercise some resistance. As Stuart put it, "*I tend to use the protocol a bit loosely and so I don't do CBT very effectively. It's not pure and that's why my supervisor raises' her eyebrows*."

Yet, whereas individuals can more easily change their views as personal experience and knowledge grow, institutional standards, legislations or rules are much harder to change. For example, John remarked that:

> *I feel like this is a confessional now – that my original preparation was Rogerian and I struggled with some elements of that in that I struggled with what I saw at the time as a lack of structure. What I believed and I still struggle with now is a kind of abdication, at times, of therapeutic engagement with the client.*

John showed he change his opinion about the value of client-centered approaches, and thereafter of CBT, just to arrive at the recognition that both approaches had value and limitations. Yet, for institutions, such an experience-driven recognition is not sufficient; the process of change is more hazardous and must be lead a collective certainty.

In contract with CBT practices, not many frames of references have been developed, tested, trained and supervised to the satisfaction of mental health institutions for their support of integrative practices (Aafjes-van Doorn, Klinar Alfaro, Fialová, & Kamsteeg, 2018; Castonguay, 2000; Sotskova, & Dossett, 2017). Such lack left Stuart uncomfortable with the use of integrative practices: "*That's one of the things I found a bit frustrating about trying to practice it, that there wasn't enough of a framework. Perhaps with CBT there is too much of a framework, [laughingly] or there can be*."

Stuart not only showed that the resistance enacted by institutions was representative of his views, as he showed once more that he recognized the value and limitations of both structured and unstructured modalities. This is indeed the clearest conclusion of the present study. Practitioners were satisfied and unsatisfied and both modalities were praise and criticized. Clinicians who were able to choose, situationally, from more than one modality, were those who were using integrative, non-pure, forms of practice. They further confessing to believe in the additive integration hypothesis exposed in Chapter 1, and resolved, either theoretically and/or pragmatically, what others perceived as incompatibility.

As explored for the wounded therapists' subtheme, and further systematized under the theme 'missing elements', obstacles to integrative practices included a personal resistance to some aspects of their CBT practices. The most common adjectives associated with CBT when expressing a personal resistance to its use were, as described in *Chapter 5*, '*cold'*, '*angry headmaster', 'excluding', 'cruel', 'abusive', 'painful', 'exposing', 'disastrous', 'mechanistic', 'dangerous and traumatising', 'rigid'* and *'stressful'*. For example, John referred that CBT *"forces people into these nomothetic categories and applies techniques, in many cases, blindly to that. I have a huge sense of frustration with that",* and Mark acknowledgment that *"It has become mechanistic, it has become very much issue-focused as opposed to client focused".* Here, the participants expressed what Schneider (2008) tried to resolve via his 'Existential-Integrative (EI)' framework, which integrates CBTs with ETs by embedding an existential dimension into CBTs practices.

In this work, in great awareness of the dangers of the 'blind' technical application discussed by John in regards to CBT, a plea to CBT professionals is made. As Schneider

(2008, p.vii) put it, "*without the existential - the understanding of a person's relation to being- such practices too often devolve into adjustment rituals, rarified or removed "strategems," that quell but do not necessarily transform*."

As Stuart, there were more participants expression their doubts about the value of ETs. For the mixed strand, participants recognized for example that "*the vast majority of my clients don't ask 'big questions*'", and preferred action-oriented approaches. Some were also unable to understand in practice how integration came about: "*I am not sure how this would fit with maintaining fidelity to CBT model"*.

For the qualitative strand, the resistance to the use of ET-based alternatives was mostly associated with its lack of structure/ evidence/ institutional support, or even, as expressed, 'esoterism'. As Ann put it:

> *I never actually know whether I'm doing it right. I couldn't say whether my technique is the same as your technique is the same as anyone else's technique, and I couldn't actually say what I'm doing that makes me existential.*

In sum, there were personal resistances to the use of CBTs, ETs and their integration. The exploration of respondents' hesitations suggested that a way of helping psychotherapists interested in the use of modalities which still raise social resistance, such as ETs or CBTs-ETs integrative frameworks, would be to develop a framework to teach, guide, assess and disseminate integrative practices, principally for those working within institutional settings. It was in this line of response that Schneider (2008) developed his integrative modality.

8.7 How new is the integration zeitgeist? Discussion overview

The present studies showed that integration, albeit perhaps against institutional guidelines, is performed by clinicians who are simultaneously satisfied and dissatisfied with CBT. When these clinicians are acquainted with modalities that they feel to address the limitations of CBT behind their satisfaction, some actively pursue integration. In most cases, as previously discussed, this integration is done naturally and with additive integration intents. It is not guided by any existing formal framework or training. As discussed, this is very much in line with the 'zeitgeist' of the new millennium. As long as personal and collective resistances to the use of integrative approaches are addressed, and emerging frameworks start to be more extensively investigated and disseminated, it is possible that such a 'zeitgeist' is here to stay.

Many examples were offered in this thesis to illustrate this zeitgeist. Even IAPT is broadening already its scope. For example, Jolley et al. (2015, p.25) investigated the access to the IAPT approved treatment of severe mental illness. As described, it is unexpectedly a standard (read, 'unspecified') 'CBT' treatment. Yet, in reading closer, one understands that it adapted the cognitive models of psychosis specifically to the emotional disturbances of those severely ill, seeks to "*promote an individualized and helpful understanding of the experience of psychosis*" and "*to foster a therapeutic relationship that is genuinely collaborative, empowering, and characterized by explicit warmth, positive regard, and transparency*". These were all aspects that some participants in both strands highlighted as lacking in CBTs and as offered by what they understood ETs and meaning-based approaches to be.

Yet, as argued in *Chapter 1*, this is not such a new zeitgeist. Since the early beginnings of psychology with Sigmund Freud, there were multiple authors who, rather than developing a completely new modality with utterly distinct tenets and goals, such as Skinner, actually sought to integrate aspects that had been already explored by other authors into their (hence, integrative in character) modalities. An example, discussed in *Chapter 1* and recognized by one or another participant in either strand, are CBT modalities like REBT and CT, which, under a certain perspective, integrated some of the assumptions and/or practices that ET's are said to employ (Ameli, 2016; Ameli & Dattilio, 2013; Armstrong, 2016; Fegg et al., 2013; Gagnon et al., 2015; Gebler & Maercker, 2014; Hickes & Mirea, 2012; Ottens & Hanna, 1998; Prasko, Mainerova, Jelenova, Kamaradova, & Sigmundova, 2012).

For some respondents and authors alike, though perhaps lacking in historical insight, these integrative efforts were particularly salient for third-wave modalities that deal with "*questions of values and meaning*" (Fegg et al., 2013, p.2079). Nevertheless, such an impression may be left due to the way modalities such as REBT started to be exercised in ways that go against the specifications of their authors. For example, REBT, that is currently accepted as a CBT modality even by its founder, Ellis (2005a; 2005b; 1995; 1980), is sometimes practised in ways that overlook its phenomenological tenets (e.g., Ellis, 1980), as apparently in Armstrong's (2016) work.

Therefore, those claiming to aim at the integration of ETs and CBTs actually should claim instead to aim at doing so more extensively. Indeed, some historical insight and rigour might benefit all those who are presently proposing 'new' modalities, and inclusively those integrative of CBTs and ETs (e.g., Loewenthal, & House, 2010). For instance,

Jolley et al.'s (2015) investigation integrated an unspecified 'CBT' with some ET principles of unknown origin and Ottens and Hanna (1998) reviewed the theoretical compatibility of CT but failed to specify which ET was at the basis of their analysis. Unlike wise, Ameli (2016) attempted to integrate logotherapy and CT, and both Armstrong (2016) and Hutchinson and Chapman's (2005) pursued the integration of logotherapy and REBT.

REBT generally seeks to guide clients towards the adoption of a new philosophy of life or core beliefs. Unlike CT, which grounds well-being mainly on rational decision-making and the eradication of NATs (Ellis, 2005a; Ellis, 1980; Dryden & Neenan, 1999; Joseph, 2012; Rosner, 2011), REBT grounds it instead on the adoption of (not necessarily rational) biopsychosocial self-helpful behaviours, thoughts, emotions and beliefs-as-'affective-reactive-attitudes' (Ellis, 2005a). That is, under REBT, well-being does not revolve around rationality; "*people are often irrational and unsane—including therapists*" (Ellis, 2005a, p.155). Secondly, there are no pre-established criteria for illness and wellbeing; any belief must be assessed in relation to the overall situation and the client's functioning.

As REBT, ETs also do not elect rationality as the main discriminator between well-being and lack thereof. Thereby, both approaches embrace a 'holistic' or comprehensive perspective of human beings. For instance, unlike CT, REBT takes into consideration the shifting of clients' diagnoses and experiences in its clinical practices, leading some to conclude that REBT is 'trans-diagnostic' (Edwards, 1990; Rosner, 2011). Interviewees from the qualitative strand of this thesis discussed at length the importance of approaching individuals in this holistic manner - though not quite so fully the importance of

overlooking the criterion of rationality for discriminating mental wellness and illness. Indeed, the latter can at best be grounded upon their discussions of the importance of taking on board clients' interest in addressing the spiritual meaning-making and 'big' philosophical issues that, as aforementioned, CBTs tend to disregard.

Despite any convergence between REBT and ETs that there may be, REBT is not an ET. At best, it is, as one of the interviewees', Robert, remarked, simply the most suited CBT for the inclusion of ET elements. Some of the aspects distancing REBT from available ETs, as Robert and the literature have recognised, include it not supporting the spiritual meaning quests that ETs generally embrace (Armstrong, 2016; Hutchinson & Chapman, 2005). As discussed in Chapter 1, most ETs-CBTs integrative efforts (Ameli, 2016; Ameli, & Dattilio, 2013; Armstrong, 2016; Gagnon et al., 2015; Gebler & Maercker, 2014; Schneider, 2008) have straightforwardly recognised the importance of doing so, many attempted to actively incorporate these discussions during integrative clinical practices, and some actually gathered support for the claim that this activity, as practised under an ET or under an ET-CBT integrated format, provides benefits such as fostering positive emotionality, hope and optimism.

Additionally, in the literature, REBT was noted to fail to embrace the importance of clients' interpersonal relationships, as these happen outside of the consultation room (Armstrong, 2016), and, by extension, non-intrapsychic life circumstances – principally when conducted in a manner that overlooks many of Ellis (1980) propositions. Interviewees' exploration of this lack, and principally in association with REBT, was meagre but did occur. Examples include the humanity theme, or interviewees' discussions about the importance of first getting a feel for the "*person in context in terms of systems*"

(Joanne), or John's commentary about how CBT was so individualistic and intrapsychic focused that it belittled the impact of people's actual situation as it unfolded in the 'real' world, when sometimes 'there were no choices'.

Moreover, in the literature and the findings alike, CBTs have been noted to be quite rigid process-wise, whereas ETs, and, to some extent REBT, are beneficially less so (Edwards, 1990; Gebler & Maercker, 2014; Hickes & Mirea, 2012; Ottens & Hannah, 1998). Indeed, although REBT, just like CT, employs an "*active-directive*" (Ellis, 2005a, p.155) approach, with three treatment stages (Joseph & Chapman, 2013), it does so more flexibly. As Ellis (1985, p. 252) explained:

> *Existential therapists […] can show their clients the possibilities of making choices and changes, but unless they actively encourage them to keep working at changing, many clients […] will only sporadically do so. REBT realistically merges existential therapy with active-directive teaching and mentoring.*

That is, under existentialist influences, REBT has mechanisms in place for a masterful conduction of a therapeutic process that is simultaneously directive but flexible, where directive should be read as motivational, and flexible as "*co-directed*" (Ellis, 1985, p.161) by both clients and therapists. Achieving this combination is very often the goal of available ETs-CBTs integrative frameworks. As Ellis noted, ETs such as logotherapy do tend to explore the realm of possibilities dialectically and adapt the therapeutic process and choice of tools in accordance with what is emerging in the present moment, in such a way that the 'co-direction' of the therapeutic process may become evident. Yet, in ETs, this flexibility is associated not only with the way therapy is process-wise adapted to the

uniqueness of each client and therapeutic moment, as in REBT, but also with a moment-to-moment way of being a therapist and relating to clients.

That is, ETs tend to go beyond the claim that flexibility is important for customising therapy. They also deem flexibility to be important to form a particular (dialectic, 'exploratory', non-directive, non-structured and fluid) therapeutic relationship with clients and/or adopting specific 'existential' therapeutic presence or attitude (Edwards, 1990; Gebler & Maercker, 2014; Hickes & Mirea, 2012; Ottens & Hannah, 1998). In this thesis, some interviewees did refer to this dimension of flexibility, further exploring at length the benefits of holding an authentic and vulnerable (as opposed to, say, 'bossy', 'know-it-all' and/or rigidly 'directive') presence in therapy, and consequently forming a relationship with clients that is power asymmetric and may be detrimental for clients. Flexibility is argued here to be of critical importance.

Therapists, principally more active-directive 'bossy' ones, can easily try to impose their own views regarding issues that can be wrought with contention and even hostility (Cardemil & Battle 2003; Hodge & Lietz, 2014). As such, while CBT can be modified to incorporate discussions of existential and phenomenological ideas, inclusively as these relate to spiritual issues, and even without making reference to ETs, it seems useful to do so under an existential attitude and form of relating. Such an attitude might prevent therapists from guiding clients towards their own, rather than towards their clients' own beliefs.

Some survey respondents expressed their doubts as to existentialism becoming more widespread within NHS settings, as the current focus within these tends towards

quantitative evidence-based approaches only. This sentiment is echoed in the literature (e.g. Lowenthal, 2010; Lowenthal & House, 2010). The emphasis on scientific truths and managerialism within current NHS therapeutic settings (House, 2003) is said to alienate from a psychotherapeutic language and translates into a shift in the locus of power away from therapists' professional expertise and autonomy towards bureaucracy and administration (Lees, & Freshwater, 2008).

The current climate of budget constraints may be seen as a disincentive to introduce any new approaches to therapy. Yet, evidence-oriented therapists and organisations should be reassured regarding the usefulness of including existential components into therapeutic frameworks. Presently, as discussed in Chapter 1, there are several qualitative (e.g., Frueh, Cusack, Grubaugh, Sauvageot, & Wells, 2006; Hodge & Lietz, 2014) and quantitative (Chambless & Ollendeck, 2001; Khoury et al., 2013) studies about the benefits of taking onboard client's beliefs and values during the course of therapy. There is further evidence pointing out that CBT's effectiveness is non-generalisable across individuals, apparently short-lived, and that alternatives addressing the deeper issues are needed (Mearns, 2003). To achieve this purpose many have proposed or developed integrative modalities (e.g. Gold, 1993; Keshen, 2006; Lantz & Walsh, 2007; McCraken & Morley, 2014).

8.8 Future research suggestions

As discussed now and then throughout this thesis, the present studies are not without their limitations. Firstly, as a by-product of sample selection procedures, mandating participants' active membership of the BABCP, and principally for the mixed strand, practitioners had a more limited range of knowledge and practical experience with ETs

in comparison to CBTs. Yet, for the qualitative strand, no matter how simultaneously interested in the use of ETs and other meaning-based approaches, these were also BABCP members. Consequently, the opinions of participants regarding ETs and CBTs are not claimed to represent the views of the general population of therapists. Instead, the value of findings is limited to the population of CBT therapists. In the overall population of therapists, those who are *not* BABCP members might express greater dissatisfaction with CBT and/or demonstrate greater knowledge and practice of ETs.

The implication of this choice for the present thesis is that interviewed and sampled participants might have a more superficial idea of what was meant when inquiring about their ET and meaning-based practices, struggling to theoretically describe and compare modalities or describe whether and how they did it in practice. As Stuart confessed, *"it might just be a thing you bring that does make my hybrid approach work better. I don't know what I'm saying. I'm getting tangled up, because I suppose that's also a matter of experience, isn't it?"*

That, it is here suggested that in the future sample selection procedures target non-BABCP members for understanding the practices of the overall British community of psychotherapists, as in the prevalence studies performed for investigating the practices of North-American practitioners previously described. This study would help to understand the community's opinion about CBT in a less pro-CBT-biased manner. This would clarify whether there are indeed approximately five times less CBT dissatisfied than satisfied participants, as here found, and the prevalence of a wide variety of practices in Britain.

It is also suggested that the opinions of British psychotherapists formally trained in ETs, such as those associated with the New School of Psychotherapy and Counselling in the U.K., are surveyed. This would clarify better about the value, use and integration potential of ET-based practices and how these practices are operationalized by psychotherapists with extensive knowledge. For example, would they claim that mindfulness was an ET-based technique, as some of the participants of the mixed strand suggested?

Additionally, for understanding better ET-CBT integrative practices, psychotherapists with strong backgrounds of both ETs and CBTs, rather than merely CBTs, as assured by their BABCP membership, should be surveyed or interviewed. This was precisely what the qualitative strand of this study attempted to do. Yet, for studies with greater quantitative intents, evening out the extensiveness of their knowledge and the use of ETs with that of CBTs might help reveal a more accurate or representative picture of therapists' opinions about the value of CBTs, ETs and CBTs-ETs integrative practices. It would also clarify whether the odds of being inclined towards ETs are apparently higher when satisfaction with CBT is lower, as here found for the minority that expressed dissatisfaction.

During the qualitative strand, there was greater extensiveness in the discussion of CBT's limitations and greater exploration of the incorporation of existentialism and other approaches in therapy. This difference seemed to at least partly be a result of data collection instruments. More weight seemed to have been given, in interviewing procedures, to respondents' dissatisfaction with CBT and how they address issues of dissatisfaction via the use of ET-related techniques.

Hence, those interested in understanding the advantages and disadvantages of CBTs qualitatively should employ more balanced interviewing procedures. On the upside, the qualitative strand of the present study did reveal several issues of contention of CBT, opening way to a deeper understanding of the CBT disadvantages that were more superficially assessed for the mixed strand and from the viewpoint of a majority of satisfied participants.

Finally, this study opened way to the instigation of the obstacles and drives of the use existentialism-based practices. Each one of these could represent a fruitful line of future research. For example, findings suggest the quality of the therapeutic relationship, achieved via CBT, is worse than that achieved via ETs, raising doubts about common-factors models integrating this variable and creating awareness about the confounding effect of the therapeutic relationship in RCTs. Similarly, therapists reservations about the exploration of big issues in therapy should be better understood. This avoidance characterized the majority of mixed strand participants and was regarded as detrimental by qualitative strand participants

In conclusion, future research suggestions highlighted in this chapter included inspecting in greater depth: the opinions and practices of the overall community of British psychotherapists (vs. BABCP members); the opinions and practices of therapists with balanced formal CBTs and ETs backgrounds; the opinions and practices of therapists with formal training and experience of ETs; the obstacles and drives of ET-CBT integrative practices; the relationship between existentialist thought, satisfaction with and criticism of CBT from the viewpoint of non-BABCP members; and the relationship between types of training and integrative practices.

Note than in any one of these lines of investigation, extra care must be paid to the aforementioned construct validity issues, such as by offering definitions of modalities while surveying respondents, or by asking participants to select practices (vs. modalities) used, as some have attempted to do for the case of North American psychologists. Moreover, as discussed in *Chapter 1*, client feedback is critical for determining the efficacy of treatments (e.g., Seligman 1995). This was not inspected in these studies. Thus, future studies might find interest in understanding clients' opinions about the use of pure, as compared to non-pure modalities.

To reassure mental health organizations and institutions about the value of the use of ETs, which was one of the obstacles of the use of ETs in this study, more evidence should be gathered in general. Since, as discussed in *Chapter 1*, RCTs might not be suited for the study of more flexible and less structured approaches, alternative research methods can be used. Seligman's (1995) consumer reports and long-term observational and comparative (of CBTs, ETs and CBT-ETs integrated frameworks) studies could perhaps amount to research methods more philosophically adequate for the study of ETs.

8.9 Final remarks

Some survey respondents expressed their doubts as to existentialism becoming more widespread within NHS settings, as the current focus within these tends towards quantitative evidence-based approaches only. This sentiment is echoed in the literature (e.g. Lowenthal, 2010; Lowenthal & House, 2010). The emphasis on scientific truths and managerialism within current NHS therapeutic settings (House, 2003) is said to alienate from a psychotherapeutic language and translates into a shift in the locus of power away

from therapists' professional expertise and autonomy towards bureaucracy and administration (Lees & Freshwater, 2008).

The current climate of budget constraints may be seen as a disincentive to introduce any new approaches to therapy. Yet, evidence-oriented therapists and organisations should be reassured regarding the usefulness of including existential components into therapeutic frameworks. A hybrid approach, containing evidence-based and philosophical elements, might help to overcome some of the potential deficits of existing CBT modalities.). To achieve this purpose, many have proposed or developed integrative modalities (e.g. Gold, 1993; Keshen, 2006; Lantz & Walsh, 2007; McCraken & Morley, 2014). In accordance with present findings, t may be particularly relevant to discuss spiritual issues, and taking relationships into account. This would already expand, as sought, the scope of therapists' interventions (Gee, Loewenthal, & Cayne, 2011

Overall, contextual constraints to the more disseminated use of integrative existentialism-based approaches cannot be addressed by clarifying and instructing therapists about the value of adopting integrative approaches in practice, including those involving existentialism. Yet, these might be attenuated by providing trustworthy evidence about such value.

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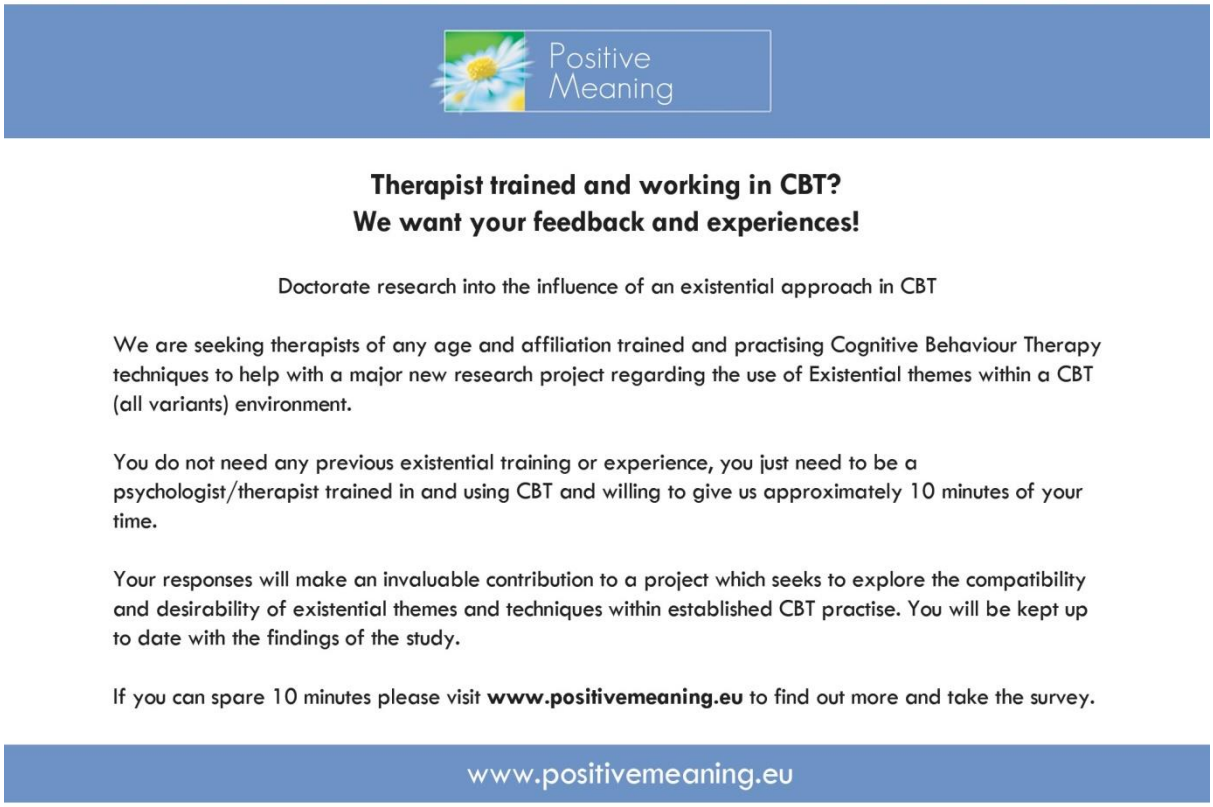
Appendix 1 - Literature review methodology

A literature search was conducted using The Library of Medicine PubMed database and Web of Science, using the search terms 'cognitive behavioural therapy' or 'CBT,' in combination with additional terms, including 'existential/existentialism,' 'limitations,' 'alternatives,' 'training,' 'effective' ‘nomothetic vs Idiographic’ and 'efficacy.' A purposive selection strategy was used to seek out specific examples: relevant published articles, systematic reviews, meta-analyses, randomised control trials, among others. Observational studies were sought which address aspects of the topic, such as existential CBT, training in CBT and its effectiveness in treatment. These subtopics of interest were revealed through close reading of key publications providing an overview, including review articles, and by referring to the IPA interviews with accredited cognitive therapy practitioners and the online research conducted for this research study before commencing a more extensive literature search. In this way, in order to tackle the review process more efficiently, a stage-based process was commissioned. This allowed the literature to be assessed in terms of its quality, as well as the development of a rigorous criteria for the identification, evaluation and synthesis of selected literature. Furthermore, review of relevant body of literature has produced a number of reoccurring topics that consistently emphasized the link between CBT and existentialism.

It is also important to acknowledge some review methodological limitations. As with most methodologies, one could argue that the present methodology has inherent limitations. For example, given the rapid advances in technology, some literature can be out-of-date even before it gets published. Moreover, the issue of selective bias can pose as another methodological limitation. In this respect, one could argue that contradicting research may have been given less importance or attention, even after standard procedure being followed. Furthermore, the influence of the ‘me’ as the reader, involved in the process of sanctioning the quality of articles. From this vantage point, it could be argued that there is always a possibility that justice may not be done to the quality and relevance of certain articles.

Appendix 2 – Advert in CBT Today published by BABCP



Appendix 3 – Research portal web site text

Pages for Research Portal Website

Research web site for a Doctorate in Counselling Psychology (DCPsych).

Accredited: BPS/HPC, School: New School of Psychotherapy and Counselling (NSPC), Course validation: Middlesex University.

Menu page bar

Banner (As part of moving picture Gallery at the bottom of the pictures)

Research into the influence of an existential approach in cognitive behaviour therapy

Home Page

'Existential Therapy deals with the most fundamental concerns now facing clients, concerns it shares with REBT and CBT clients' – Albert Ellis, (2007),Overcoming Resistance, Springer, New York.

All participants must be trained and experienced in the use of CBT.

Welcome to Positive Meaning - This portal is a user-facing component of an on-going research project into the use of existential approaches within cognitive behaviour therapy (CBT).

The purpose of this portal is to present a survey regarding therapist satisfaction with CBT and the use of existential themes and thinking.

Each participant who completes the survey will be contacted with an outline of the study once it is completed.

We hope you will take the time to complete this survey, as your responses will be invaluable in the completion of the first comprehensive study to address therapists' experiences and thoughts regarding the use of CBT and existential techniques within a practical therapeutic environment.

About CBT Page

'CBT aims to help clients learn new and adaptive ways of functioning. As a process this is usually active, progressive, interventive, time-limited and goal oriented' – Gary Bakker, (2008), Practical CBT, Australian Academic Press, Melbourne.

Cognitive Behavioural Therapy (CBT) is a well-established and widely used form of therapy which has grown from decades of behavioural and conditioning research. Its earliest roots can be traced back as far as 1920, and in the years of its growth it has adapted and incorporated a wide range of processes and techniques from earlier methodologies, including coaching, rehearsal, modelling and reinforcement.

CBT aims to produce measurable results by changing unhelpful ways of thinking and behaviour patterns into those which are more beneficial for the person undergoing therapy. It concerns itself with the provable and the manifest; it does not concern itself with wider metaphysical or spiritual questions.

Clients undergoing CBT present specific problems or groups of problems which they seek to resolve, and the therapeutic process involves a series of interactions aimed specifically at producing measurable results in the cessation or alteration of these problematic behaviours and behaviour chains. The process is strongly collaborative; however the therapist takes the role of educator, trainer, coach and reinforcer where appropriate.

About Existential Therapy Page

'The focus is therefore on life itself, rather than on one's personality. The aim is to assist people in developing and consolidating their personal way of thinking.' – Emmy Van Deurzen, (2002) Existential counselling & psychotherapy in practise, Sage, London.

Existential therapy takes a holistic view of the individual and their relationship to the world. Specific problems are considered in relation to a client's wider world-view, and rather than emphasising short-term and goal-oriented achievements, existential therapy instead seeks to place the client in a more healthy relationship with their own being and their perceived experience of the world.

Often coupled with a phenomenological approach, existential therapy is concerned with wider themes such as identity, meaning, responsibility, choice and the underlying assumptions regarding the self and the universe which govern everyday actions and shape belief systems. It

is predicated on philosophical rather than medical research, and as such, is less concerned with the diagnosis and resolution of one specific problem, and more involved in the tracing or delineation of the threads which bind an individual's psychological behaviour and outlook.

Existential therapy tends to require a longer time-frame, and is less concerned with measurable results than other forms of therapy. A client may attend therapy to resolve a specific issue, and find that this relates to a far wider network of issues within their own lives.

Existential therapy sessions are a collaborative process, one in which the therapist initiates a dialogue, sometimes directed but often free-roaming, to encourage the client to view the therapy session as a safe environment in which to discuss issues they may not have had the opportunity to consider in the past. In many ways the existential therapist is a facilitator, eschewing forms of dialogue which could be understood as dogmatic in favour of an open and honest investigation of a client's position in relation to the wider world.

Why help with our research? Page

Your completion of this survey will offer invaluable quantitative and qualitative data from a practical and human perspective to ensure that this project offers a real contribution to the development of support networks, training programmes and therapeutic paradigms within the fields of CBT and Existential Therapy.

It is vital that the field of therapeutic research listens to active therapists so that these experiences are the starting point for subsequent investigation. Projects such as this also offer the opportunity for a more holistic perspective on therapist satisfaction, gathering diffuse experiences which may not otherwise be considered together.

This is an opportunity to share your experiences anonymously (with this survey subjected to rigorous confidentiality safeguards) and to contribute to a project which we hope will be of real benefit to therapists like yourself. It will not normally take more than 10 minutes of your time, and you will receive an outline of the projects findings once the work is completed.

No knowledge of existential therapy is required to take the survey, however, we ask that all participants must be trained and experienced in CBT.

Take the Survey Page

The online survey consists of **three short questionnaires** which typically take **no more than 10 minutes in total**. There is also an optional section for you to provide additional detail, and we would be very grateful for as much information as you wish to provide. The more data and experiences we have, the more complete and useful the projects' observations and conclusions can be.

The sections are broken down as follows:

5. CBT Satisfaction (CBT-S), to investigate your satisfaction with CBT in practise.
6. Scale of existential thinking (SET), intended to assess your own form and degree of existential thinking.
7. CBT with an Existential dimension (CBT-E), to investigate the possibility of integrating CBT with existential themes.
8. Optional free response questions to allow you to add further detail or make further comments on the issues raised by the survey.

ENTER SURVEY

Contacts page

Main contact - researcher: Dr Melvyn Flitman (office@positivemeaning.eu) +44 (0) 7767 009912

Research supervisor: Dr Andy Fox (andyp.fox@gmail.com)

School: New School of Psychotherapy and Counselling (NSPC) (www.nspc.org.uk) , 254-256 Belsize Road, London, NW6 4BT, Tel: +44 (0) 207 624 0471 e-mail: admin@nspc.org.uk

Further Resources Page

http://www.nspc.org.uk **- New School of Psychotherapy and Counselling** – providers of the BPS accredited Doctorate in Counselling psychology

http://www.bps.org.uk – **The British Psychological Society** – the hub for all UK based psychologists and therapists

http://www.babcp.com – **The British Society for Behavioural and Cognitive Psychotherapy** – The UK's accreditation body for CBT practitioners.

http://www.arebt.org – **Association for Rational Emotive Behaviour Therapy** – The UK's accreditation body for REBT practitioners.

http://www.birmingham.ac.uk/schools/psychology/centres/rebt/index.aspx –**Centre for Rational Emotive Behaviour Therapy** – the University of Birmingham's Albert Ellis accredited REBT training faculty

http://www.rebtnetwork.org – **REBT Network** – an information resource page on many aspects of REBT

http://www.rebt.org – **The Albert Ellis Institute** – US REBT teaching and learning institute

http://www.cbtregisteruk.com – **CBT Register UK** – Online register of CBT therapists within the UK

http://www.societyofpsychotherapy.org.uk – **Society of Psychotherapy** Different practitioners discussing common issues of practice.

Appendix 4 – Online survey

PsychData Surveys

Page 1 of 1

PREVIEW MODE: Responses will NOT be stored.

Survey #146874 (Need help?)

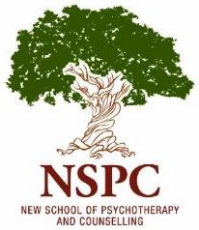
Please select the appropriate choice

New Participants

This is the first time you are answering questions to this survey.

This survey is configured to let you to save your work and continue later.

CBT satisfaction and existential thinking online survey



Middlesex University School of Health and Social Sciences Psychology Department

Title of Project: A phenomenological analysis of existential attitude in cognitive therapists

Researcher: Dr Melvyn Flitman (office@positivemeaning.eu)

School: New School of Psychotherapy and Counselling (NSPC)

(www.nspc.org.uk)

, Course: Doctorate in Counselling Psychology (DCPsych). **Accredited :** BPS/HPC

Research supervisor: Dr Andy Fox (andyp.fox@gmail.com)

Your unique Respondent ID# is: 2750318 (Print this page)

Participant information

Invitation

You are invited to contribute to a research study. Before you decide to participate,it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it will others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part. office@positivemeaning.eu

What is the purpose of the research ?

This online survey contributes to a doctorate in counselling psychology research project the aim of this online survey is to assess practitioner psychologist and trained cognitive therapist satisfaction with CBT and possible links with existential thinking. The data will be analysed using quantitative methods. The doctorate is the NSPC DCPsych doctorate validated by Middlesex University and accredited by the BPS and HPC. (http://www.nspc.org.uk/)

This information will be used in conjunction with a separate part of the research that consist of in-depth interviews with eight participants who use an existential dimension in their CBT. This will be analysed using Interpretative Phenomenological Analysis (IPA)

This research is important as it will add to the body of knowledge about psychological therapy.

Outline of the questionnaires used in this survey

This online survey consists of four questionnaires:

1. CBT satisfaction (CBT-S) to investigate satisfaction with CBT
2. Scale of existential thinking designed by psychologists to assess existential mindset
3. CBT with an existential dimension (CBT-E) to investigate possible integration
4. Optional free response questions provides the opportunity to make valued comments

What will happen to this information ?

The data collected will be mainly subject to quantitative analysis. The optional free response questions may be subjected to qualitative analysis. Anonymous sections of the information collected from the online survey will be looked at by my supervisor , and may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project.

As part of the doctoral program , I will write up a report of the research . Within this report I may include anonymous extracts of the data collected from this online survey . I will also write a paper for publication in an academic journal, this may also include brief anonymous extracts of the data collected. There is the potential that the research findings maybe presented at conferences in the future , this would not include any information that could identify participants.

What will happen to me if I take part ?

Your participation to this online survey is limited to the time it takes you to compete.

What are the possible disadvantages and risks of taking part?

There are no known disadvantages or risks with taking part. If you wish to make contact to discuss your experiences of participating in this survey including to inform me of any unforeseen negative effects or concerns, please email me at : office@positvemeaning.eu

Who is organising and funding the research?

The organisation and funding of this research is by myself (Dr Melvyn Flitman), under research supervision and within the requirements of the NSPC - Doctorate in Counselling Psychology (DCPsych) as accredited by the BPS and HPC. Validated by Middlesex university.

Consent

Participation in this research is entirely voluntary. You do not have to take part if you do not wish to. You will be asked to to read the informed consent on the next page when you click continue saying that you have read and understood this information and consent to participate.

Withdraw from participation and rights to withdraw from study

You can with draw at anytime now or in the future. You can have your data removed at anytime up to submission of the research project. Please contact me at the email address : office@positivemeaning.eu

Who has reviewed the study

All proposals for research using human participants are reviewed by an ethics committee before they can proceed. The Middlesex Psychology department ethics committee have reviewed the proposal.

Confidentiality

All data is kept confidential and participants are only identified by a participant ID number which is generated automatically by the Psychdata software. All data is encrypted. All identifying data will be removed from any data and verbatim quotations that will be written into any report , dissertation and publications. All participants will be allocated a pseudonym upon publication of any data. The information will be kept at least 6 months after I graduate.

Contact details for the researcher

Melvyn Flitman: c/o NSPC, 254-256 Belsize Road, London, NW6 4BT, Tel: +44 (0) 207 624 0471

e-mail: admin@nspc.org.uk

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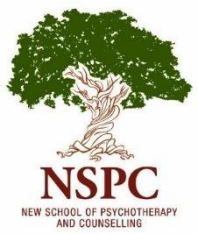

Middlesex University School of Health and Social Sciences Psychology Department

Informed Consent

Title of Project: A phenomenological analysis of existential attitude in cognitive therapists Title of Survey: CBT satisfaction and existential thinking online survey

Researcher: Dr Melvyn Flitman (office@positivemeaning.eu)
Doctorate in Counselling Psychology (

I have understood the details of the research as outlined in the previous page of this online survey, and confirm that I have consented to act as a participant by clicking the 'continue button' at the end of this page.

I consent to acting as a participant

I have been given this e mail address office@positivemeaning.eu as contact details.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide maybe used for analysis and subsequent publication, and provide my consent that this might occur.

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by

Continue » Save and Exit

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Information about you

What is your occupation (Please select one or more)

- Clinical Psychologist
- Counseling psychologist
- CBT trained therapist
- Counselor
- Other (please specify)

What setting do you work in ? (Select all that apply)

- Primary care
- Secondary care
- IAPT
- Private practice
- Voluntary
- Commercial
- Education
- Other (please specify)

What is your accreditation body (Please enter one or more) 1.

2.

3.

4,

5.

* What is your gender ?

Female

Male

* What is your age ?

* How many years have you been using Cognitive therapy ?

* Would you be willing to be interviewed about your experience of using CBT with an existential approach (Maximum of eight participants will be interviewed)

Yes

No

Continue ONLY when finished. You will be unable to return or change your answers. (Need help?)

Continue » Save and Exit

PREVIEW MODE: Responses will NOT be stored.

CBT-S - Satisfaction levels among CBT trained therapists/psychologist regarding CBT techniques

Instructions:

Please indicate to what extent you agree or disagree with the following

* I find CBT techniques provide me with all the tools I need in my therapeutic work

○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly agree

* I would be comfortable using CBT techniques with my client regardless of the issues they present

○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

* My training in CBT techniques covered a comprehensive base of potential client issues

○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

* I have found CBT to be effective in situations involving the discussing of 'big issues', e.g. the purpose of life , the existence of God , anxiety of identity

○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

* I have in the past guided therapy sessions away from 'big issues' because I was unsure of how to use CBT to deal with them

○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

* I feel comfortable in freely adapting the CBT techniques learned during training

○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

* Overall I am satisfied with the use of CBT with my clients

○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

* I integrate other approaches (e.g. psychoanalytic, existential , systemic etc)

○ Strongly disagree ○ Disagree ○ Neutral ○ Agree ○ Strongly Agree

Continue ONLY when finished. You will be unable to return or change your answers. (Need help?)

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SET - The scale for existential thinking

Instructions

Select the answers that best fit for you either now or in the past

* Do you ever reflect on your purpose in life ?

☐ No or rarely ☐ Sometimes ☐ Often ☐ Almost all the time ☐ All the time ☐ I don't know

* Have you ever think about the human spirit or what happens to life after death ?

☐ No or rarely ☐ Sometimes ☐ Often ☐ Almost all the time ☐ All the time ☐ I don't know

* Have you ever spent time reading, thinking about or discussing philosophy or your beliefs ?

☐ No or rarely ☐ Sometimes ☐ Often ☐ Almost all the time ☐ All the time ☐ I don't know

* Do you have a philosophy of life that helps you manage stress and crises or make decisions ?

☐ No or rarely ☐ Sometimes ☐ Often ☐ Almost all the time ☐ All the time ☐ I don't know

* Do you think about ideas such as eternity , truth, justice and goodness ?

☐ No or rarely ☐ Sometimes ☐ Often ☐ Almost all the time ☐ All the time ☐ I don't know

* Do you spend time in prayer, meditation or reflecting on the mysteries of life ?

☐ No or rarely ☐ Sometimes ☐ Often ☐ Almost all the time ☐ All the time ☐ I don't know

* Do you discuss or ask questions to probe deeply into the meaning of life ?

☐ No or rarely ☐ Sometimes ☐ Often ☐ Almost all the time ☐ All the time ☐ I'm not sure

* Do you ever think about a 'grand plan' or process that human beings are part of ?

☐ No or rarely ☐ Sometimes ☐ Often ☐ Almost all the time ☐ All the time ☐ I don't know

* Have you ever thought about what is beyond the 'here and now' of your daily life ?

☐ No or rarely ☐ Sometimes ☐ Often ☐ Almost all the time ☐ All the time ☐ I don't know

* Do you ever think about life's Big Questions ?

No or rarely	Sometimes	Often	Almost all the time	All the time	I'm not sure

* Have you ever reflected on the nature of reality of the universe ?

No or rarely	Sometimes	Often	Almost all the time	All the time	I'm not sure

Continue ONLY when finished. You will be unable to return or change your answers. (Need help?)

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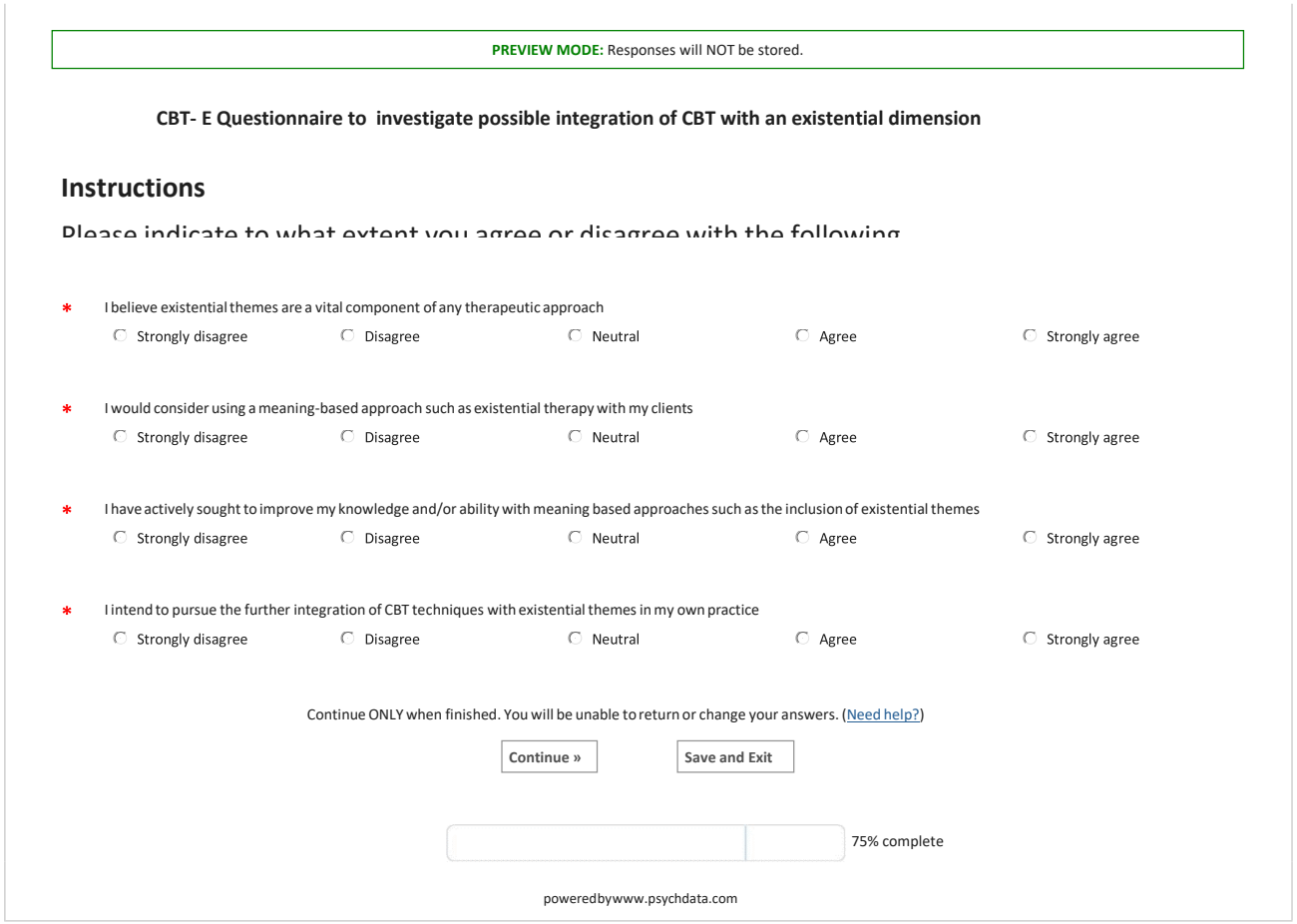

PREVIEW MODE: Responses will NOT be stored.

CBT- E Questionnaire to investigate possible integration of CBT with an existential dimension

Instructions

Please indicate to what extent you agree or disagree with the following

* I believe existential themes are a vital component of any therapeutic approach

Strongly disagree Disagree Neutral Agree Strongly agree

* I would consider using a meaning-based approach such as existential therapy with my clients

Strongly disagree Disagree Neutral Agree Strongly agree

* I have actively sought to improve my knowledge and/or ability with meaning based approaches such as the inclusion of existential themes

Strongly disagree Disagree Neutral Agree Strongly agree

* I intend to pursue the further integration of CBT techniques with existential themes in my own practice

Strongly disagree Disagree Neutral Agree Strongly agree

Continue ONLY when finished. You will be unable to return or change your answers. (Need help?)

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Optional free response questions provides the opportunity to make valued comments

Instructions

This is an **optional section** , which gives you the opportunity to make comments.

Outline your current awareness of meaning-based approaches/existential themes, including

any training you have received or personal research you have undertaken.

(28000 characters remaining)

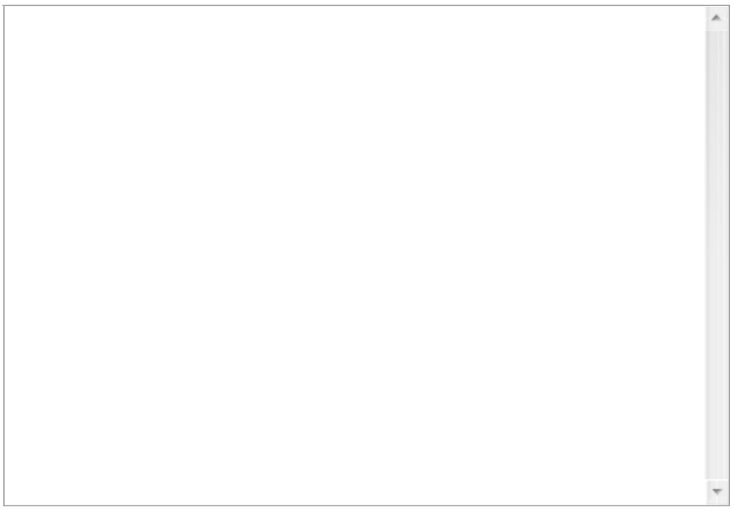
If you have integrated existential themes into your CBT sessions in past. outline your motives

for doing so. If you have not, please outline your reasons for not doing so.

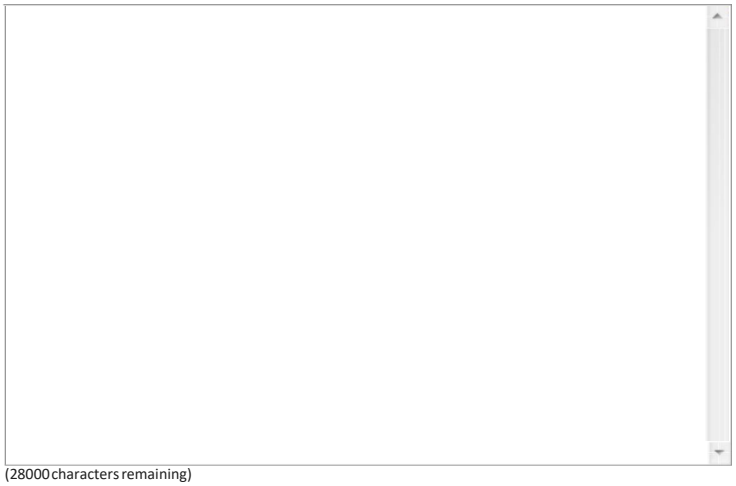
(28000 characters remaining)

If you would consider integrating existential themes into your CBT sessions in the future, what would you hope to achieve by doing so?

(28000 characters remaining)



If you have any other comments please provide below.



(28000 characters remaining)

Continue ONLY when finished. You will be unable to return or change your answers. (Need help?)

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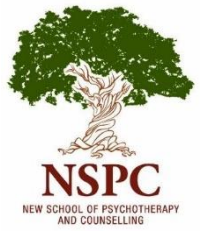

Middlesex University School of Health and Social Sciences Psychology Department

Debrief

Project Title: A phenomenological analysis of

existential attitude in cognitive therapists Survey Title:

CBT satisfaction and existential thinking online survey

Researcher: Dr Melvyn Flitman (office@postivemeaning.eu)

School: New School of Psychotherapy and Counselling (NSPC)

(www.nspc.org.uk)

Course: DCPsych). **Accredited :** BPS/HPC

Research supervisor: Dr Andy Fox (andyp.fox@gmail.com)

Thank you for your valued participation

About this Study

This study forms part of my research dissertation as part of a BPS/HPC accredited Doctorate in counselling psychology. The research is in two parts.

You are only participating in **Part 1 -** this online survey on

therapist/psychologist satisfaction with CBT and its relationship with existential thinking.

Part 2 is a separate study; in-depth interviews with therapists/psychologists who are trained in cognitive therapy and attempt to integrate existential ideas/therapy into their work.

About the Tests

The MIDAS Existential thinking scale which form part of this study was designed by psychological researchers to measure variables which may be important in existential intelligence. The satisfaction with CBT questionnaires CBT-S and CBT-E were designed by me.

The Results

You will receive an e-mail with an outline of the study results as soon as the work is complete. Please contact me if you have any questions about any aspects of the study.

Your experiences of this study

If you wish to make contact to discuss your experiences of participating in this survey including to inform me of any unforeseen negative effects or concerns, please email me at : office@positvemeaning.eu

Rights to have your data removed

You can have your data removed at anytime up to submission of the research project. Please contact me at the email address: office@positivemeaning.eu

Create Account Sign In

PREVIEW MODE: Responses have NOT been stored.

CBT satisfaction and existential thinking online survey

Your unique Respondent ID# is: 2750318 (Print this page)

Thank you!

Invite Another to Participate

To	(email to whom)
From	(email from whom)
Your Name	(first and last name)

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