Chapter 7: About the position of existential themes in cognitive behavioral therapy

Abstract
In cognitive behavioral therapy (CBT), many topics can be addressed, including far-reaching themes such as death anxiety. Does it belong to the profession of CBT therapist to discuss these kind of concerns? And if so, is he adequately equipped for this task? This chapter highlights existential concerns from the perspective of a psychotherapeutic movement that has traditionally given much attention to this topic. These existential psychotherapies are compared with CBT of the second and third generation. Next, a translation to practice is made by discussing the treatment of death anxiety. This chapter concludes by discussing the above-mentioned questions and by giving recommendations for practice and future research.

7.1 Introduction

His hand with the marker pen hovers in front of the whiteboard for a moment. He looks over his shoulder and wonders if he has understood this well. Did she really say that she’s known this all along? With an ingeniously executed Socratic dialogue, he had let her discover that panic attacks are not dangerous, let alone that you can die

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10 This chapter is based on:


and

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from them. And now she says that she already knew this. What is going on then? He listens to her explanation. She cannot digest, cannot live with the fact, that she will die someday. And that is what she is afraid of. Always, but especially during a panic attack. Should he challenge this thought? Is it better to ignore it and return to the schedule? Can you even challenge death anxiety? Use Downward Arrow?

The experience of this cognitive therapist will be recognizable for many colleagues. In a patient’s fear (e.g., fear of rejection, panic attacks, or serious illness), the great themes of life often play a role. As a result, the conversation leads to topics such as death, loneliness, alienation, meaninglessness, or guilt. The therapist’s confusion may also be recognizable. Discussing such topics is not easy, so there is a risk of avoidance. This chapter discusses the existential perspective on psychiatric problems, and aims to understand to what extent this perspective is consistent with the common practice of behavioral therapy. Does discussing such topics even belong to the profession of CBT therapist? And if so, does he find enough tools in his tool box to get started? To answer these questions, we first explore the topics of existential questions by examining the movement of the existential psychotherapies; an approach that focuses on clarifying existential questions. Next, we compare this movement with cognitive behavioral therapy, in which we also consider a new development: Acceptance and Commitment Therapy (ACT). A further translation into practice takes place when we discuss the topic death anxiety, and present the therapist from the introduction again. Finally, we will evaluate the above in the discussion and give recommendations for practice and research.

7.1.1 Existential psychotherapies
The field of psychology is still young, but the human tendency to think about one’s own existence is much older. Centuries before our era, religious writings already discussed this, and the Greek philosophers wrote about mortality and what makes life profoundly meaningful. In the twentieth century, philosophical insights were translated into the practice of psychotherapy. The work of philosophers Kierkegaard, Nietzsche, Heidegger, Sartre, and Camus played a major role here. The therapy itself became a philosophical investigation that set out to clarify life questions. Especially the work of American psychiatrist and group psychotherapist Irvin Yalom and the books of Viktor Frankl have familiarized a wider audience with this movement. Of Frankl’s book Man's Search for Meaning (about
logotherapy), that was partly based on his experiences as a prisoner in a concentration camp, millions of copies were sold worldwide.

There are major differences between psychotherapists who claim to work “existentially”. What is important here, is that freedom and variability are highly valued in the existential philosophy. For these therapists, the philosophy is often an at least equally important source as the (empirical) psychology. A critical attitude exists towards a complaint-oriented approach, and human existence is approached in the broadest sense, in which suffering is seen as an integral part. Most forms of existential psychotherapy, except logotherapy, have criticized the use of standardized interventions, which they see as a threat to genuine attention to the individual story of the patient (Cooper, 2003). The phenomenological method is most typical of the existential therapeutic practice. Within this method, the therapist learns to become aware of his own presuppositions, to be able to listen to the story of the patient as open-mindedly as possible, and to only look for a common thread or recurring themes in second instance (Van Deurzen & Adams, 2011).

A field of application that has traditionally given much attention to existential questions is the care of people with a somatic disease. This is not surprising: The confrontation with illness, limitations, and threat of death often leads to awareness of existential questions. This applies to both conditions with a short life expectancy and diseases with a chronic course (Breitbart et al, 2010; Swildens, 2004). An existential perspective also offers advantages for the treatment of a somatoform disorder (e.g., chronic pain), concerning concepts such as suffering, values, acceptance, living with limitations, and meaning (Gebler, 2010; Gebler & Maercker, 2012). Existential psychotherapies are also used in a wide range of psychiatric problems, including psychotic disorders, depression, anxiety, and personality disorders. Cooper (2003) argues in favor of defining the scope more clearly. For instance, existential psychotherapy should focus on those patients who seek clarification of existential questions, and not so much on the reduction of psychopathological symptoms.

7.1.2 Existential themes

Thus, there is no unanimity on the area on which the existential psychotherapies should focus. Some therapists start from a perspective that is as broad as possible. The therapy should focus on “life in general”, where everyday experiences are just as relevant as questions about meaning. Several others have tried to come to a theming of so-called
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“ultimate concerns” or existential fears (Glas, 2001; Tillich, 1952; Yalom, 1980). The format of Yalom has become especially known:

Death: Yalom sees fear of death as a collection of more concrete fears (e.g., pain, loss of loved ones, having to let go of projects, loss of control). However, he predominantly focuses on the “not being there anymore”, which he points out as the core. With reference to Kierkegaard, he sees this as a form of anxiety instead of fear with an object, which makes it so difficult to handle this fear.

Freedom: This is about the realization that you, as a human being, are free to choose, but that also makes you solely responsible for your life. There is a vertiginous number of options to choose from, while at the same time, it is impossible to know the outcome of your choices in advance. This can evoke an experience of “groundlessness” and lead to a situation in which choices are avoided as much as possible.

Isolation: The term isolation can be used when it concerns the separation from others or the closure of parts of a person's inner self. In existential sense, however, it concerns the fundamental separation between the own person and others/the world. Every human being is locked up in the own world of experience that one cannot escape. This can evoke a fundamental sense of loneliness.

Meaninglessness: Yalom distinguishes “meaning” (the experience of coherence) from “purpose” (the experience of future goals that are worth pursuing). He includes both aspects in his description of meaninglessness. He also distinguishes “cosmic meaning” from “terrestrial meaning”. The first concerns the question of the overall meaning of life; the second concerns the question of what makes one's personal life meaningful. Yalom’s principle is that there is no universal “meaning”: People create their own meaning.

Experiences of meaninglessness can often be traced back to problems with one of the other existential realities or to cultural artefacts, such as the principle that an ultimate meaning of life should be distinguishable or that a life without external meaning would not be worth living. The above descriptions concern general human experiences and not something that is exclusive to people with a psychiatric problem. According to Yalom (1980), psychiatric problems can arise when someone is not able to handle these realities of life well and develops inadequate strategies for doing so. We will address this further in the discussion of death anxiety.
7.2 Comparison of existential psychotherapies and cognitive behavioral therapy

Based on the description given in 7.1.1, the differences between CBT and the existential psychotherapies appear great. A complaint-oriented approach contrasts with a person-oriented approach, and standardized interventions contrast with a listening attitude that is as open as possible. Nevertheless, there have been several attempts in recent years to compare existential therapies with cognitive behavioral therapy, and to examine the extent to which integration is possible (Bornstein, 2004; Butcher, 1984; Corrie & Milton, 2000; Dyck, 1987; Edwards, 1990; Hutchinson & Chapman, 2005; Kissane et al., 1997; Noyon & Heidenreich, 2007; Ottens & Hanna, 1998). Except Dyck (1987), all authors conclude that irreconcilable differences appear to exist at first glance, but that many similarities emerge upon close comparison and integration turns out to be possible. Below, we will address differences and similarities between cognitive behavioral therapy and existential psychotherapies, and the question of how much attention is paid to existential issues within CBT.

7.2.1 CBT: differences and similarities

Traditionally, CBT literature has mainly relied on the findings of empirical psychology as opposed to philosophy. Insofar as a justification is given of its philosophical principles, this is especially found within the cognitive tradition that regularly relies on the Epicurean and the Stoic philosophy. These philosophers advocated pragmatism and a rational attitude towards life. There is also affinity with Taoism and Buddhism (Beck, Rush, Shaw, & Emery, 1979). Albert Ellis has dedicated a relatively high proportion of his work to the philosophical underpinnings of his approach; the rational emotive therapy (RET) (Hutchinson & Chapman, 2005). In his underpinnings, he also referred to existential psychotherapists. Ellis (2003) sees the importance that rational emotive therapy attaches to involvement in the world in accordance with Frankl, and the principle of unconditional acceptance of the other in accordance with Tillich (1952).

CBT helps people to adapt as well as possible to the conditions of life. Korrelboom and Ten Broeke (2004) mention this adaptation as a fundamental philosophical principle, not only of CBT, but of psychotherapy in general. This principle logically goes hand in hand with a pragmatic attitude towards life questions. The content of these questions is less relevant than the effect they have on the process of adaptation. For example, concerning the treatment of depression, Beck (1979) recommends to let the “philosophical questions” of the patient rest at the beginning of a therapy, because these often prove to be no longer important later on.
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When they are, they can still be addressed, but Beck does not describe how this can be done. Dyck (1987) goes one step further and states that the question of the meaning of life is irrelevant in a therapeutic setting, because it cannot be answered on empirical grounds. It is up to the therapist to clarify this for the patient. In the light of the foregoing, it is logical that a pragmatic and complaint-oriented approach is dominant in manuals on behavioral therapy. However, existential fears, as described above, can also be found in CBT literature. Walen et al. (1992) give the example of a patient suffering from experiences of meaninglessness. The therapist could then ask “What would make life meaningful for you?”, and then focus on the answer to this question. Following Ellis, they also point out the disadvantages of a demanding attitude to life, such as the view that the world should absolutely be fair and just. Negative thoughts about the inevitabilities of life only make the situation worse: Aside from suffering from these aspects, you will suffer from what you imagine about this in your head. Moreover, due to the emotional turmoil that you are experiencing, you will be less able to come up with solutions to problems that can be solved. The therapist can apply cognitive interventions, such as the Socratic dialogue or a cost-benefit analysis, to discuss this with the patient. Several authors also pay attention to the treatment of death anxiety, which we will discuss in the next section. Finally, existential themes are especially addressed in therapies that were specifically designed for personality problems, such as schema-focused cognitive behavioral therapy (Edwards, 1990). Here, the term social isolation is used. In contrast to the existential psychotherapies, these themes are addressed as part of the events in a person’s life history and less as a general human given (Bornstein, 2004). The patient who was neglected as a child and who developed the schema “social isolation” as a result, can learn through therapy to enter into relationships and to connect with others. However, at some point, she may realize that this does not change the fundamental disconnection that she shares with all other humans: “I am myself and I can never truly know what goes on in others and vice versa”. Those who work with people with personality problems will probably recognize that these people often have an exceptional talent for articulating the great themes of life. In addition to the fear that a new partner will once again prove to be untrustworthy, they realize that people are (can be) generally unreliable and that one has to live with that fact. People with a secure attachment history seem to be better able to maintain the pleasant illusion of the contrary (Mikulincer, Florian, & Hirschberger, 2004).
7.2.2 ACT: differences and similarities

Both representatives of ACT and representatives of existential psychotherapies believe that ACT has more kinship with the existential philosophy in comparison with the second-generation cognitive behavioral therapy (Harris, 2010; Sharp, Schulenberg, Wilson, & Murrell, 2004). ACT would therefore constitute a correction to one-sidedness in the development of behavioral therapy. ACT is similar to the existential psychotherapies in the choice of objectives for the therapy: Symptom reduction can be a beneficial side effect, but it is not the primary goal of the therapy. The primary goal is that the patient is better able to live in accordance with his or her values. A difference is that ACT is firmly placed in natural science, while the ratio of existential psychotherapies and this scientific view is complex, ranging from a virtually complete rejection (Mahrer & Boulet, 2004) to a sympathetic but critical approach (Cooper, 2003; Schulenberg, 2003).

Both approaches rely on oriental traditions of thought and attach great importance to philosophical underpinnings in general. Hayes, Strohsal, and Wilson (1999) argue that theoretical development should always be accompanied by philosophical reflection. This promotes coherence in theory, and clarifies the connection with other theoretical fields. It is also a form of accountability: You are showing where you stand, instead of letting presuppositions play a more implicit role.

Besides these similarities, a difference stands out. The central idea in the philosophical underpinnings of ACT is that man is a linguistic being. This has given him many benefits in evolutionary terms, but also provides many problems nowadays. Because of language, man is able to suffer from events that are actually not taking place. The “functional contextualism”, in which this idea is developed, is akin to the postmodern philosophy of language. Supporters of the latter are of the opinion that the question of whether language also refers to a particular objective reality cannot be answered. Language, the entire network of meanings, is approached as an isolated phenomenon.

Hayes, Strohsal, and Wilson (1999) devote a few words to the phenomenon of “existential anxiety” as an example of how language allows people to make ever-finer distinctions in the things for which they may be anxious. Somewhat ironically, they point out that man is able to first verbalize existential anxiety, and then flee from it. According to the same authors, the philosophy behind ACT is “a-ontological”, by which they mean the adoption of a pragmatic truth criterion. It is not a question of what reality looks like, but of how we can function as effectively as possible. Concerning this point, there may be tension between the existential psychotherapies and ACT (Cooper, 2003). On philosophical grounds, one can stick to the
position that man can never step outside of the own network of meanings, and that the question of whether a thought is “true” cannot be answered. However, people’s everyday experiences are different. The thought “I will be dead later on” takes on a whole different meaning in the waiting room of the oncologist than on a random Saturday afternoon, during a walk in the park. In this sense, it matters whether a thought is “true”. Language is not isolated, but serves to interpret the world. Experiences with the world confirm or correct our views (Harding, 2005).

Here, it may be argued that also within ACT, attention is paid to events that people experience. Many authors even emphasize that suffering is an integral part of human existence (although certainly an ontological statement). A distinction is made here between “clean pain” (inevitable life events and the mental response to it) and “dirty pain” (getting caught in thoughts and feelings and the problems created by experiential avoidance; A-Tjak & Groot, 2008). Apparently, people live not only in a network of meaning, but also in the world. A strict separation between these would not do justice to the human experience. The attention paid here to a possible tension between ACT and the existential psychotherapies does not detract from the earlier statement that representatives of ACT also consider existential questions to belong to the domain of their therapy. For example, Harris describes that many people are struggling with experiences of meaninglessness, and how living from values can act as an antidote against this (Harris, 2009). Within ACT, death anxiety is also mentioned regularly. In the following section, we will present the recommendations that are given on this topic.

7.3 Application: death anxiety
The therapist mentioned in the introduction to this chapter was struggling with the question of how to help his patient who experiences death anxiety. In this section, we will first discuss death anxiety in general and then discuss how representatives of the above-mentioned therapeutic approaches could address this.

7.3.1 Death anxiety
Death anxiety is an appealing and challenging topic. The fear itself is widely recognizable and yet, almost all people find a way to cope with it. Sometimes, this will not work well for a period of time, and almost all therapists will remember patients with a very pronounced fear
of one's own end of life. The threat of a serious illness or the death of a loved one can lead to an increase in death anxiety (Butcher, 1984). When guiding people with pathological mourning, for example, it can be good for that reason to explicitly ask them if they are also more concerned with their own end of life. “Sometimes, people who lose a loved one also think about their own finitude a lot. Is that also the case for you?”

Research on death anxiety shows that it is a multidimensional concept (Fry, 2003). Awareness of one's finitude for some especially concerns letting go of loved ones, and for others the possible impossibility of one’s own existence, pain, or the demise of the body. The intensity and nature of this fear also seems to differ in the course of life. On average, death anxiety is present most pronouncedly in middle age, after which it decreases. A possible explanation is that in middle age, the discrepancy between one’s own desires and the expected life time is the largest. However, mental well-being is a more important factor in explaining differences in death anxiety than age or other demographic factors (Conte, Weiner, & Plutchik, 1982; Fry, 2003). Confidence and especially a positive assessment of one’s own ability to solve problems turn out to be an important protection against death anxiety (Lehto & Farchaus Stein, 2009). Death anxiety can play a role in various forms of psychopathology. Noyes et al. (2002) studied hypochondria, on the basis of which they even state that fear of one’s own finitude provides a better explanation model than a perceptual or attachment model. Several authors point out that it is striking how little attention has been paid to the topic of death anxiety in psychotherapeutic literature. Unease about this topic probably also plays a role here (Yalom, 2008).

7.3.2 The treatment of death anxiety: existential psychotherapies

Therapists from this field emphasize, among other things, that death anxiety can be seen much broader than merely the fear of one's own end of life. Dying is a lifelong process. This not only holds true for processes in one's own body, such as the constant dying of cells, but also for the irreversibility of time. Life can only be lived forward: What has been will never come back (Cooper & Adams, 2005). The finitude of life is seen as a task that every person has to deal with, even without the existence of an actual threat of dying. People relate to their finitude in a certain way. The fact that some pay little conscious attention to their finitude is just as striking as the fact that others are giving it much attention.

Within the existential approach, much thought has been given to the question of how people make death anxiety manageable. Yalom (1980) refers to both narcissism and a dependent
attitude in this context. In response to death anxiety, people can see themselves as exceptional, which allows them to maintain the illusion that they will escape “the great equalizer”. Another way to avoid having to face one’s own death anxiety is a strong dependence on a rescuer figure. Experimental research showed that confrontation with death stimuli leads to a higher estimate of the intensity of relationships (Bornstein, 2004). Yalom assumes that a part of psychopathology can be understood as an inadequate way of coping with death anxiety, where the patient is often not or only partly aware of this background of the symptoms. It is up to the therapist to clarify this with the patient. Learning to face and endure one’s own finitude can pave the way for a life that is experienced as more authentic and meaningful. To be able to properly guide the patient in this process, it is important that the therapist is able to face his or her own finitude. In addition, exposure to death anxiety (i.e., talking about it in therapy) and clarifying death anxiety (“So how do you imagine your death?”) are seen as important tools (Yalom, 1980). Others have pointed out that an excessive fixation on death anxiety may suggest avoidance of other issues, such as important decisions that should be taken and the responsibility to take life into one’s own hands. In that case, the therapist will try to broaden the focus (Cooper & Adams, 2005). Death does not have to be avoided as a topic, but talking about it should not lead to avoidance of life.

7.3.3 The treatment of death anxiety: cognitive behavioral therapy
Death anxiety may play a large role in anxiety disorders, for example, in people with a panic disorder or a swallowing phobia. In literature on cognitive behavioral therapy, the therapist is instructed how to help the patient be less afraid of this catastrophe. Cognitive techniques show the patient that the probability of one’s own death is much smaller than expected, and behavioral experiments can strengthen this conviction. It is important to note that there is a difference between the actual fear of dying at a given time and death anxiety in general. As the patient indicated in the introduction, many people know very well that they will not die just like that, but some find it particularly difficult that the end will come at some point. For these patients, it does not matter much that the probability of getting a heart attack is exceptionally small for healthy people in their forties. As far as this existential side of death anxiety is discussed in protocols, it is only discussed indirectly. A commonly used protocol for the treatment of panic disorders (Kampman, Keijsers, & Hendriks, 2011) includes a comment that the patient might be afraid of dying and of having to leave her children to their fate, upon which the protocol merely notes: “Attention should also be given to this latter,
basic thought” (p. 47). In a reaction to the article that underlies this chapter, Korrelboom and Ten Broeke (2014) also recognize that there is little attention in CBT protocols for treating existential problems. As a concession to this limitation, they suggest that it can be useful to offer a customized treatment based on meaning and function analyses. This can, for example, clarify the role of certain anxious imaginations in the symptoms and how these were formed. From this analysis, certain interventions can be chosen carefully, such as challenging thoughts or learning to distance oneself from imaginations that are difficult to refute, but that do have a negative effect. Korrelboom and Ten Broeke mention several interventions that can prove useful in this regard, such as writing exercises, Competitive Memory Training (COMET), Attention Training Technique (ATT), and influencing anxious anticipation with the so-called Flash Forward technique.

Perhaps patients with death anxiety can also be helped by exposure to the feared stimuli, as Persons (1986) describes in an article about a successful treatment. In sixteen sessions, the patient was exposed to the characteristics that were most threatening to her, with the help of, among other things, books about death. As a result, her anxiety strongly decreased. When it comes to exposure, the question of what exactly the patient should be exposed to is interesting. Information about the funeral, burial rights, and the process of dying can potentially be seen as acquired knowledge that has become connected to one’s own death anxiety due to a learning process. Through exposure, this connection will get a less prominent place in the network of meaning, and the fear will decrease. However, some characteristics of death anxiety, for example the fear of choking, are so basic that it is questionable whether these were acquired by a conditioning process. In the treatment of swallowing phobia, Ball and Otto (1994) combine exposure with the exploration of death anxiety and the process of dying. Walen et al. (1992) argue that death anxiety can be seen as a form of “awfulizing”; there will always be a worse disaster imaginable, even when it comes to death. As an example, they mention that it is always possible to imagine a process of dying that is even more painful and slow than the death that you are fearing yourself. This intervention will probably not appeal to every patient.

Jacobs (1998) describes the treatment of a woman with fear of flying, and how it is possible to work on acceptance of the fact that there are situations where it is impossible to bring yourself to safety, for example when you are in a crashing plane. The patient learned to accept death as well in her therapy, as the ultimate consequence of such a situation. In this respect, Walen et al. (1992) establish a relationship with mourning; a process that takes place according to stages, at least according to Kübler Ross’s popular model to which they refer.
Similarly, the therapist can help the patient to go to the next stage in the acceptance of death. This example, just like several other examples, does not explain how the patient can be helped to achieve this.

7.3.4 The treatment of death anxiety: Acceptance and Commitment Therapy

Also within ACT, attention is paid to the topic death anxiety. As an example of a defusion technique, Harris (2010) notes that you can create distance to a thought by singing it to a funny tune. He makes the humorously intended remark that of course, this intervention should not be applied with a terminal patient when it comes to the thought “I am going to die”. Later on in the same book, he simultaneously gives instructions on how to go about this and describes how he helped a patient with a life-threatening illness to distance herself more from her “story of the scary death”. The author mentions that when so-called insoluble problems arise, the therapist will help the patient to get out of the problem-solving mode and to adopt an attitude of mindfulness and acceptance. This last advice seems to find support in a study that found that people with a more mindful attitude towards life are on average less burdened with death anxiety (Niemiec et al., 2010). Whether a similar effect is also achieved by interventions is a topic for further research.

7.4 Discussion

The goal of this chapter was to clarify how much attention is paid within CBT to existential questions, and whether the CBT provides sufficient tools at this point. To gain more clarity, we discussed the movement of existential psychotherapies and mapped differences and similarities with CBT. Due to the very broad objective, this comparison only took place in a general sense. For example, we ignored the theoretical principles of behaviorism and how these relate to the emphasis on personal freedom that is placed by existential thinkers. Next, we addressed the treatment of death anxiety, which showed that all three therapeutic movements advocate an open attitude towards this topic; an attitude that, depending on the therapeutic preference, could be further characterized as authentic, rational, or mindful. Thus, do existential questions also belong to the area of the CBT? And if so, is the CBT therapist adequately equipped for this task? The first question can be answered affirmatively. While in CBT, the emphasis lies on a complaint-oriented approach and therefore, naturally, less attention is paid to underlying, more philosophical questions, several authors do give
examples of CBT treatments in which life questions played a large role. They also recommend the tools of the CBT therapist, including cognitive interventions and exposure, for helping people who are struggling with these questions. In recent times, ACT therapists have drawn particular attention to this aspect of behavioral therapy; a development that fits well with a recent plea for the development of a person-oriented approach in mental health care, in addition to the complaint-oriented approach (Bohlmeijer, 2012; Westerhof & Bohlmeijer, 2010).

Regarding the next question, of whether the tools of the CBT therapist are also effective in this area, caution should be exercised. As far as specific interventions were found in CBT literature, the descriptions are relatively brief and it is unclear whether these interventions are effective when it comes to existential experiences. More detailed descriptions can be found in literature on existential psychotherapies. However, generally speaking, there is still little known about the effectiveness of this treatment method. At this point, there seems to be a need for further research.

CBT therapists could gain inspiration from the literature on existential psychotherapies, and translate these insights into testable hypotheses. The Terror Management Theory has shown that such research is feasible. In this experimental tradition, research has been conducted in recent decades on the relationship between death anxiety and attitudes (Koole, Greenberg, & Pyszczynski, 2006).

An example of possible research: Yalom’s theorem that an excessive belief in one's own uniqueness is related to death anxiety, could be tested by introducing this topic in the treatment of people with a narcissistic personality disorder, and by determining whether the treatment of this death anxiety, by cognitive interventions or exposure, leads to therapeutic success. One can also imagine that struggling with life questions plays a larger role for some patients, and that the therapy should be adjusted accordingly. Addis and Jacobson (1996) show that cognitive therapy works better than behavioral activation when helping people who give an existential explanation for their depression. Concerning patients with therapy-resistant problems, descriptions of existential experiences or using a questionnaire can help to determine whether it would be better to focus on these topics. Here, it can also be studied whether, for example, learning mindfulness skills indeed has a positive effect. A good questionnaire for measuring existential experiences is of great importance to this kind of research (Noyon & Heidenreich, 2007). Such a questionnaire can also be used to determine whether learning to use existential experiences is a mediating factor in achieving treatment success, and whether this factor possibly plays a greater role when treating certain patient
groups. With this in mind, we developed and validated the Existential Concerns Questionnaire (ECQ), as discussed in the previous chapters.

Finally: Both ACT and the existential psychotherapies, as well as several CBT therapists emphasize the importance of philosophical reflection. Taking note of different life visions and reflecting on one’s own views help a therapist to come well prepared and to be able to note and discuss life questions; what one does not know, one will not recognize. Of course, there is a role for supervision and learning therapy here. Without this training, the therapist may miss important questions of the patient or unintentionally impose his or her own views on the other.

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role of trait mindfulness in reducing defensive responses to mortality salience.


