Received: 21 March 2023 | Revised: 9 May 2023 | Accepted: 16 May 2023

DOI: 10.1111/jep.13872

REVIEW ARTICLE

Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research
WILEY

Using values in cognitive and behavioral therapy: A bridge back to philosophy

Sylvia Martin PhD[1,2]

[1]Center for Research and Bioethics, Uppsala University, Uppsala, Sweden

[2]Clinical Psychologist specialized in CBT, Psycho-TCCE Private Practice, Nîmes, France

Correspondence
Sylvia Martin, PhD, Husargatan 3, BMC, entrance A11, Uppsala, Sweden.
Email: Sylvia.martin@crb.uu.se

Abstract

Ancient therapeutic practices have influenced the development of cognitive behavioral therapy (CBT) theories such as Albert Ellis's rational emotive behavior therapy and Aaron Beck's cognitive therapy. By drawing inspiration from Socratic questioning, the importance of philosophy in evidence-based practices in human mental health can be acknowledged. Stoicism has also informed CBT, notably its emphasis on establishing psychological distance from emotions. Cognition and emotion are two aspects of mental processes, and irrational demands are processed through rational deliberation. Using mental imaging techniques and acceptance strategies (to accept oneself and the world as imperfect), avoiding catastrophic interpretations and acknowledging emotions are also included among such practices.

Methods: We will explore the use of values across CBT, acceptance and commitment therapy (ACT), and radically open dialectical behavioral therapy (RO DBT) to clarify their use of values.

Results: In this framework, values are conceptualized as life-orienting principles and are now widely used across CBTs, such as acceptance and commitment therapy and radically open dialectical behavioral therapy. In recent years, the development of CBT has involved a renewed relationship with philosophy through the use of values, interest in dialectics and development of self-questioning practices reminiscent of classical Socratic principles. This movement from applied clinical psychology toward philosophical skills has also encouraged the recent emergence of philosophical health considerations. The opposition between psychological and philosophical health can be questioned, and the fundamental issue of philosophical skills implemented in psychiatric treatment (and not solely as practices of enhancement for the sane) needs to be considered.

KEYWORDS

ACT, cognitive behavioral therapy, philosophical health, RO DBT, values

1 | INTRODUCTION

In every care service, some values are commonly thought to structure both the workplace and the workers. In the psychiatric field, we have a 'kind treatment' (*bientraitance*) movement comparable to the 'care' movement,[1,2] and the most recent trend is the autonomization (*autonomisation*) of the patient in psychiatric care.[3,4] Medical doctors adopt ethical notions and values at the beginning of their careers with their commitment to the Hippocratic Oath, engaging themselves to the 'not harming' and 'never do injustice' principles. Moreover, the ethical code of conduct of psychologists deals with strong value-laden concepts such as respect, autonomy, anonymity, confidentiality and nonharming. The values of psychiatric professionals do not prevent the recurrent emergence of specific ethical issues (e.g., about compulsory care, adolescent consent and forensic care) and strong debate regarding discrepancies in the underlying values of certain therapeutic interventions. One such debate concerns child treatment procedures where a certain evidence-based treatment can be deemed harmful by some practitioners and the right treatment by others (e.g., ABA therapy or behavioral therapy for autistic children).[5] In a globalized world, a WHO fact sheet reminds us of the core values we should all keep in mind: trust, fairness and justice, safety, evidence-based treatment and autonomy.

The field of psychiatry has repeatedly faced ethical issues about values that support decision-making. The topic of mental illness often comes with questions about autonomy and responsibility and even legal issues where professional, societal, and stakeholder values are at stake (e.g., forensic care and compulsory care).[6,7] Even though psychiatry looks like a field that focuses on avoiding negative values, it is also a field where we can find emancipatory processes as well as values that empower users and support their development toward upholding new positive values. In recent years, users' perspectives have been increasingly incorporated, influencing a shift toward autonomy, reduced discrimination and the inclusion of society in promoting positive change. In psychiatry, several well-known efforts have been made to counteract discrimination, for example, the depathologizing of homosexuality and attention to transgender issues,[8] increased attention to traumatic amnesia issues, and rejecting the iatrogenic theory of 'false memories'.[9]

When moving toward more medical treatments and evidence-based applied clinical psychology (e.g., cognitive behavioral therapy, CBT), the values underlying the treatment have tended to be disguised and erased; the roots of certain therapeutic practices have been severed to make these practices 'accessible' to any public and to allow caregivers to defend themselves against any proselytism* concerns.[10] One of the most relevant examples in the CBT field is the implementation of mindfulness-based cognitive therapy (MBCT), where meditation techniques have been extracted from their Buddhist tradition via a 'clarification' process, detaching exercises from their roots in ancient spiritual approaches that were already called 'training the mind'. MBCT and mindfulness-based stress reduction (MBSR) have been created from ancestral practices associated with strong underlying values and processes, such as compassion and equanimity.[11–13] The general impression is that, in a process of medicalization, clinical psychology has left out the humanities and philosophy, and the shift toward evidence-based and CBT sealed the change.

However, philosophy and ethical values have not been totally erased from CBT. Ancient therapeutic practices have influenced the development of CBT theories such as Albert Ellis's rational emotive behavioral therapy and Aaron Beck's cognitive therapy. These eminent, pioneering psychologists made no secret of being inspired by Socratic questioning[14,15] and Socratic philosophy,[16] and they acknowledged the importance of philosophy in human mental health. They were also inspired by Stoicism, one goal of which is to establish psychological distance from emotions, treating cognition and emotion as two aspects of mental processes and treating irrational demands as negotiable through rational deliberation. Using mental imaging techniques and acceptance strategies (to accept oneself and the world as imperfect), avoiding catastrophic interpretations and acknowledging emotions were already included in Stoicism. Together with so-called third-wave CBT techniques and the development on manualized therapy to treat 'hard-to-treat' disorders, most such therapies included a philosophical component and returned to a more holistic approach inspired by bio-psycho-social models that position mental health at the conjunction of biological, psychological, and social–relational health.[17] One of the best representatives of this tendency is dialectical and behavioral therapy. To treat borderline personality disorder (BPD) patients, 'dialectics', as theorized in philosophy,[18] is used to support the skill training meant to encourage a balanced state between opposites, creating a now acceptable tension in the patient. To bring the opposites together, participants are trained in both acceptance and change, in both over-regulating and under-regulating, improving their adaptability.[19] As BPD is characterized by intense emotional, behavioral and relational dichotomization (i.e., everything being extremely good or right can switch to everything being bad or wrong), teaching its sufferers dialectics, offering potential for mitigation, was a revolution. This revolution is still expanding to new applications such as aggressive behavior, suicidal behavior, depression, eating disorders and anxiety (see Delaquis et al.[20]).

In the recent development of CBT, skill training techniques increasingly use values to address patients' motivation and self-centered orientation. For example, in acceptance and commitment therapy (ACT)[21,22] and radically open dialectical behavioral therapy (RO DBT),[23,24] values are used to improve change implementation and maintain motivation in psychotherapy. This emphasis on values that are sometimes patients' values, and sometimes the values of society or therapists, can be misleading and confusing. Nevertheless, we think that philosophical attention to values can enlighten clinical psychology and guide its practices.

2 | A STEP FURTHER WITH THE USE OF VALUES IN CBT

2.1 | ACT

ACT was created by Hayes et al.[25] and introduced value clarification, value-oriented actions and the value-based evaluation of change; for

*To induce someone to convert to one's faith.

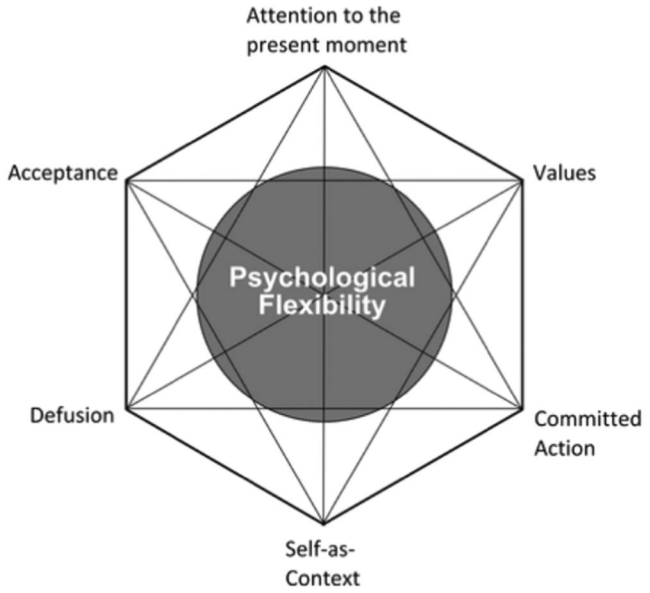

FIGURE 1 The hexaflex model in ACT.

examples of value clarification exercises, see the online supplementary material 1 of Russ Harris[26] and Steven Hayes.[27,28] ACT rates the importance of values based on their implications for different domains of life, such as relationships, health and well-being, work/career, education and personal growth, leisure, spirituality and community. People can work on 'committed actions' (i.e., value-oriented actions) in different areas of their lives[29,30] and create a 'life compass' that can used to orient their actions toward a value-impregnated life.[31] According to the 'hexaflex' presentation (see Figure 1), the main aim of the treatment is to encourage psychological flexibility by fostering committed action, presence in the moment, seeing the self as context, cognitive defusion,[†] acceptance and values.[33] The aim is to help the patient move toward internal coherence, building a pragmatic and integrative world conceptualization.[34] The patient will then be able to orient themselves and direct their actions toward a value-based life that brings meaning to experience and inhibits the patient's avoidance tendencies.[35,36]

Villatte (in Wilson[37,pp.30–39]) defined values as 'sources of overarching, intrinsic and positive reinforcement', explaining that values support a global and independent reinforcement process. This reinforcement does not happen through just a few selected actions, but through all kinds of actions, big and small, that embed meaning that can represent one's engaged living by putting one's values into action. For example, a person who values curiosity can engage their values by trying to add a new ingredient to a cake recipe and watching the outcome, or engage in a research field as a scientist. Experiencing values in everyday life can then be easier, and ACT suggests specific exercises to do that (i.e., matrix, life compass and value clarification exercises), making meaning available at any time and in any place. These values will act as a pole star helping the patient orient toward a meaningful life, and they will become a strong motivational tool, making change accessible and integrating it in the patient's life. Villatte wrote: 'Intrinsic reinforcement means that reinforcement doesn't depend on the outcomes of actions but is instead inside the action. Doing the action per se is reinforcing, because it is symbolically related to a value' (Villatte, quoted by Levin et al.[38,p.31]). One can understand that this can offer autonomy and independence from actions based on emotions, community morals and family history. On the other hand, it can be difficult to explain to patients what these 'independent' values are. In the clarification process, some patients may feel that they can only find themselves reflected in 'good' or 'moral' values as commonly understood. It can be difficult to claim values that are not socially positively valued (e.g., excitement, fun, industriousness and power). It is not easy to detach oneself from the hedonic approach to value even though the theoretical background explains it as follows: 'Feeling good or bad as a result of doing the action is not relevant to its meaningful quality. How other people judge this action, and what it produces as a consequence is not relevant either in the context of valued living. Of course, people generally desire and find satisfaction from pleasant feelings, social approval and positive outcomes; but values provide a layer of reinforcement that is more stable, less sensitive to contextual variations and thus more liberating' (Villatte, quoted by Levin et al.[38,p.37]). This explanation can be too complex and clinicians may be forced to simplify their explanations of values by stating that 'values' give meaning and direction to one's life and actions, whereas 'objectives' are only goals that, when reached, do not create a sense of accomplishment but, on the contrary, can create a moment of despair when they are finally attained ('And now what?').

A classical illustration entails comparing the realizing of an objective-related action with realizing a value-based action. For example, we think of pursuing objectives, believing that realizing them will make us feel 'fulfilled', accomplished and 'happy', even after considering the list of objectives commonly expected to be realized (e.g., 'get your license', 'find a good job', 'get a spouse', 'buy a house', 'get a dog' …). However, most people experience deception, a kind of despair when facing reality: they do not feel persistent satisfaction from realizing objectives. Success simply fades. In ACT we illustrate this using the objective 'going to Beijing', as in 'I want to go to Beijing'. The patients will save money for the trip, dedicate themselves to learning Chinese and spend hours planning their visit. When they arrive there, they enjoy themselves a lot, but what do they experience when returning home? They feel empty, purposeless again and will usually just jump to another 'final goal', but this never-ending pursuit is tiring and leads to helplessness and depression. Whereas if one pursues one's values, it is like following a path: one always finds contentment in each little action and step, no matter the goal, feeling that one is heading in the right direction. Similarly, if one wants to travel east, one will never feel disappointed: as one will focus on the direction and never actually reach the destination 'east', there will be no end to the learning process. One will always have a way to renew

[†]The process of learning how not to get caught up in thoughts and cognitive content that are interrelated with emotions. 'Defusion (fusion): it is the process of distancing from the literal products of language and cognitions (thoughts, beliefs, memories, words, judgments, etc.), learned through defusion techniques (metaphors, paradoxes and experiential exercises), to see them for what they are and not as unquestionable truths and reasons for action or inaction; the aim is to bring the person's behavior back to the control of direct contingencies (the five senses) rather than of language'.[32,p.A56]

one's motivation, always find little actions that can lead one 'east' (representing a life orientation based on living according to core values). The final assessment of living and acting within one's values is that one feels better; in the context of treating psychiatric disorders, such a value orientation improves one's depression and releases one's stress. Using values in such a way superficially recalls a hedonic view of mental health (i.e., following what makes one feel content), but the latest developments in CBT techniques offer a less obvious approach.

2.2 | RO DBT: Dialectics and valued goals

In a recent CBT development to address overcontrol disorders (in which perfectionism, rigidity and rule-oriented behavior are common), the option of relying on hedonic values can even have iatrogenic effects, as the population with such disorders has biologically based difficulties accessing body-emotion signals,[39] relies too much on planning and rule-governed behavior and can use their 'values' to rationalize their rigid and 'moral' rules. Psychotherapy then needs to emphasize values that promote in the patient a moral need to strive for improvement. In this approach, the definition of value is simplified as a person's belief as to what constitutes good character traits, such as 'being ethical', 'being open-minded', 'cultivating healthy self-doubt' and 'loving and being loved' (see Supporting Information: Appendix 1). This can seem like an egocentric perspective, but the values are all oriented toward developing better intimacy and improved significant relationships. This use of values should be seen from the perspective of the previously mentioned use of values based on the hedonic perspective. In RO DBT, the use of values is dedicated to a guidance/motivational purpose as in ACT,[40] but the overall skill training focuses on nonemotional (i.e., nonhedonic) pursuits. The focus is on putting oneself 'at one's edge', connecting to one's 'ultimate limits', putting oneself in a position of discomfort where the learning can occur. Values are connected to other skills training relating to self-exploration (e.g., self-enquiry, healthy self-doubt and self-revelation practices), which is not necessarily soothing but can use discomfort to guide change. For example, patients are trained to be at ease with their 'edge'[24]; they are trained to come to a place where change can occur and to recognize this from the discomfort they experience when starting to step out of their own rule-governed behavior, going just a little out of their comfort zone. The general focus cannot be on feeling serenity, peace or comfort (as in ACT), due to the specificity of the population. The reinforcement must be based on the sense of relief from one's edge and on refraining from finding a solution, from controlling everything. CBT seeks to develop a wide range of such value-related skills. Here is where the potential for value work in clinical psychology relates to philosophy.

2.3 | Values work: Why detach values from their philosophical meaning?

Values are life-orienting principles helping people find their life directions, giving them a sense of how to set up meaningful goals for themselves.[24] Recent psychotherapy research indicates that the process of psychotherapy can lead to changes in value-based outcomes for mental health patients and could, as such, significantly explain people's quality of life, over and above symptom reduction.[41] Value engagement influences therapeutic change to promote mental health and increase the quality of life.[42] Research indicates that value-based change can even help with hard-to-treat disorders such as BPD, where value-based work improves symptoms associated with hopelessness, BPD symptomatology, psychological flexibility and emotional issues.[43,44]

Values, then, motivate action and help individuals find meaning in their lives and actions, but are these values different from, or do they need to be differentiated from, philosophical engagements with values and ethics? Philosophy has a long history of emphasizing values to orient human decision-making and behavior. The classical distinction of intrinsic versus extrinsic values, for example, could be of great use to help patients gain autonomy and responsibility outside their own culturally related morals, which could be debilitating and create guilt or shame.[45] Intrinsic values refer to the fact that something is good in 'itself' or 'as such', and this intrinsic nature of certain values is difficult to identify and communicate without referring to the philosophical tradition.

The exclusion of normative considerations to turn 'values' into 'evidence-based' skills (and only that) could be considered fruitless (as the ethical dimensions of the concepts of virtue and character appear in the research of behavioral scientists despite attempts to eliminate them) and problematic (interesting and important psychological questions remain unaddressed because they are obviously and inevitably ethical). As a dogma wearing the mantle of 'science', the exclusion of virtue and character from the behavioral sciences[46] appears inadequate but could reflect the stigmatization of philosophical reasoning as practically unusable. In recent years, psychotherapies have even evolved toward single-value focused work, as in compassion-focused therapy,[47] which comes from 'oriental' (including Sufic) and Asian traditions and practices of self-compassion and loving-kindness. Altruism, compassion and kindness have been studied for centuries in philosophy and have informed ethics.[48,49] Recent developments of a philosophical approach in psychotherapy, counter-balancing the general tendency to avoid philosophically inspired practices in healthcare (Loughlin, in prep.), offer another vision. This is coherent with the notion of 'well-being therapy',[50] which could strengthen or complement CBT approaches.

2.4 | Philosophical counseling should more often be integrated in CBT

In recent years, a new type of mental distress has been studied as a form of 'moral suffering' in healthcare staff, social workers and police officers who daily are confronted with the shock of experiencing their values being torn apart,[51–53] creating compassion fatigue and mental distress. This underlines the importance of integrating values and respect to prevent mental disorder. In another area, climate change, we find mental disorders that seem to be brought about by disrespect of values, creating concern in young adults such as solastalgia[‡] and eco-anxiety.[54,55] These

are new disorders that create another level of conceptualization: here the fear is not exaggerated, the depression is not about the loss of any symbolic element, but is all about experiences of dramatic changes that call into question core beliefs, core values and central motivations of humanity more generally and not only in individuals. The CBT therapy field is therefore assessing the best way to address these issues and the need to return to methods that involve philosophical reasoning and philosophical skill training.[56]

An interesting response to the need to integrate values into psychotherapy and to respond to profoundly human ethical concerns today could be philosophical health.[57–59] The definition of philosophical health refers to the possibility that there could be a field of counseling envisioned as 'therapy for the sane', which could bring a person to 'new health' in which one can find coherence between one's experience (e.g., behavior, emotion and psychological stability) and 'a certain idea of what the collective and holistic good of humans and all beings on earth might be'.[57,58,p.92] Psychological health could seem distinct from philosophical health, but their interrelation is not difficult to see. It has previously been claimed that philosophy can bring peace of mind.[60] Wittgenstein spoke of therapies in philosophy, of treating a philosophical problem as an illness and of philosophical work as work on oneself, on how one sees them and what one demands of them. Another philosopher has pointed out that 'good health also includes a feeling that one's behavior is in rhythm with one's basic values. This feeling may also include a sense that life has a meaning and is worthwhile'.[61,p.7] The core maxims of Kantf[62]—that is, '(1) think for oneself; (2) think into the place of the other; (3) always think consistently with oneself'—could be relevant as CBT principles of bio-psycho-social theorization[17] in which mental health is thought to depend not only on self-equilibrium but also on social context, harmonized relationships and metacognitive abilities (i.e., reflection on one's own thinking, the ability to put oneself in someone else's shoes). Recent evidence-based therapies such as RO DBT[63] even aim to treat hard-to-treat disorders (e.g., ASD, anorexia and resistant depression) based on self enquiry and social ability restoration, avoiding the previous focus of most CBT psychotherapy on emotions as well as the hedonic approach. With the appearance of the philosophical health movement,[57,58] a possibility opened to go beyond the use of dialectics (as employed in dialectical and behavioral therapy with CBT) and broaden the integration of philosophy into psychotherapy. Recently developed practices in CBT (e.g., RO DBT) use skills comparable with deep listening and emphasize the recurrent instruction 'Ask, don't tell', which curbs the therapist's desire to correct patients' beliefs, interpretations, or ways of thinking.

An example of the renewed relationship between psychotherapy and philosophy is the clarification and use of values in ACT, which connects to the notion of 'deep orientation' (i.e., the second principle of philosophical health[57,58]). The concept of deep orientation refers to Hadot's notion of 'profound orientation', which is meant to support the efforts of philosophical health to 'guide the person via concepts, ideas or beliefs made explicit, so that her engagement with life is coherent with her engagement with ideas and works'.[57,58,p.72] In addition, the time-related approach in deep orientation, which offers both active care toward the future and informed use of the past, stands for a broadened use of values in ACT, which mostly directs patients toward the future. Implementing philosophical skills in clinical applied psychology, not only for 'healthy' individuals but including those with psychiatric disorder symptoms, needs to be tested.

3 | DISCUSSION

Attempts have been made to apply psychological methods originally intended for 'healthy' people with certain problems to psychiatrically ill patients. Positive psychology, for example, which has a strong philosophical basis,[64,65] was claimed to be an effective add-on to psychiatric intervention, as it was designed to strengthen positive attitudes, reinforce and maintain positive emotions and have a strong motivational effect.[66,67] This approach had a strong preventive effect but had some iatrogenic effects on psychiatric patients.[68,69] For example, the approach could create shame in some patients for failing to 'feel good', or put pressure on them to have 'good feelings' and to idealize a state of joy or a 'positive attitude'. An attempt was made to assess its effectiveness through meta-analysis, but the approach stayed in the small effect range and most of the interventions were based on self-help approaches mostly not directed to psychiatric samples (only four of 40 included studies were in hospital settings[70]). Specific disorders with high inflexibility may even perceive 'happiness value' as a danger, pointing to the shortcomings of working with hedonic rather than value-based approaches to happiness.[71] Depending on personality traits, individual values may not lead to well-being,[72] which indicates that the use of values in CBT should be more carefully and extensively studied. An extensive dialogue between philosophical health specialists and CBT experts could lead to better understanding of the proper use of value-based work and to more thoughtful recommendations regarding CBT treatment for psychiatric populations.

This research has several limitations. First, the author has no expertise in the field of philosophical health. More dialogue across disciplines, from philosophy to clinical psychology and psychiatry, must be carried out to develop the proposed arguments. Another limitation is that this article is based on a scoping review and not on a systematic literature review. Further research is needed to develop a more systematic overview of the use of value-based approaches within the CBT field and psychiatric research. Finally, this research mainly includes research from Western European countries, which will bias the analysis of the arguments on a more global level.

4 | CONCLUSION

The so-called third wave[73,74] developed CBT in the direction of mind-training techniques (e.g., mindfulness, metacognition, and insight therapy), which made the connection with philosophy, ethics, and values more obvious. Philosophical health opens up a new path that

‡Distress experienced by a person in the face of losses or changes in their immediate environment due to climate change.

takes us beyond the somatic and psychological health paradigm. This path could complement CBT development through its focus on techniques that support flexibility and self-inquiry (asking questions about one's personal limits without rushing to find answers) and meditative methods (e.g., loving-kindness and compassion practices).

AUTHOR CONTRIBUTIONS

Sylvia Martin made substantial contributions to the conception and design of the work, and to the acquisition, analysis, and interpretation of the data. Also, drafted the work and revised it critically for important intellectual content, approved the version to be published, and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

ACKNOWLEDGEMENTS

The author expresses her gratitude to Matthieu Villatte, who provided support and suggested references for the ACT theory, and to professors Luis de Miranda and Michael Loughlin, who encouraged this work and shared references to strengthen the exploration of philosophical health principles. The author would also like to warmly thank her colleague and understanding proofreader, Pär Segerdahl, associate professor of theoretical philosophy.

CONFLICT OF INTEREST STATEMENT

The author declares no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

ORCID

Sylvia Martin http://orcid.org/0000-0002-3706-7669

REFERENCES

1. Devigne M. Produire la bientraitance. *Gérontol Soc*. 2010;33133(2):145-157.
2. Péoc'h N. Bientraitance et éthique du care… Similitudes et différences autour d'une recension des écrits scientifiques. *Rech Soins Infirm*. 2011;(2):4-13.
3. Hammell KRW. Empowerment and occupation: a new perspective: autonomisation et occupation: une nouvelle perspective. *Can J Occup Ther*. 2016;83(5):281-287.
4. Sapiro G, Brun E, Fordant C. The rise of the social sciences and humanitiesin France: institutionalization, professionalization, and autonomization. *Shaping Human Science Disciplines: Institutional Developments in Europe and Beyond*, 2019:25-68.
5. Wilkenfeld DA, McCarthy AM. Ethical concerns with applied behavior analysis for autism spectrum "disorder". *Kennedy Inst Ethics J*. 2020;30(1):31-69.
6. Arboleda-Flórez JE. The ethics of forensic psychiatry. *Curr Opin Psychiatry*. 2006;19(5):544-546.
7. Helmchen H, Sartorius N, eds. *Ethics in Psychiatry: European Contributions*, 2010.
8. Zijlstra I. The turbulent evolution of homosexuality: from mental illness to sexual preference. *Soc Cosm*. 2014;5(1):29-35.
9. Berntsen D, Rubin DC. Involuntary memories and dissociative amnesia: assessing key assumptions in posttraumatic stress disorder research. *Clin Psychol Sci*. 2014;2(2):174-186.
10. Le Menestrel S. 2019. Chasing the Avatar. Controversies, Certification and Ethics in the Emerging Scientific Field of Mindfulness. HAS report (hal-02167248v1).
11. Kabat-Zinn J, Lipworth L, Burney R. The clinical use of mindfulness meditation for the self-regulation of chronic pain. *J Behav Med*. 1985;8:163-190.
12. Kabat-Zinn J. Mindfulness-based stress reduction (MBSR). *Constr Hum Sci*. 2003;8(2):73.
13. Segal ZV, Teasdale JD, Williams JMG. 2004. Mindfulness-based cognitive therapy: theoretical rationale and empirical status.
14. Neenan M. Using Socratic questioning in coaching. *J Ration Emot Cogn Behav Ther*. 2009;27:249-264.
15. Vittorio LN, Murphy ST, Braun JD, Strunk DR. Using Socratic questioning to promote cognitive change and achieve depressive symptom reduction: evidence of cognitive change as a mediator. *Behav Res Ther*. 2022;150:104035.
16. Cavanna AE. Stoic philosophy and psychotherapy: implications for neuropsychiatric conditions. *Dialogues in Philosophy, Mental & Neuro Sciences*. Vol 12, 2019. 1.
17. Bolton D, Gillett G, Bolton D, Gillett G. The biopsychosocial model 40 years on. *The Biopsychosocial Model of Health and Disease: New Philosophical and Scientific Developments*, 2019:1-43.
18. Hegel GWF. *The Logic of Hegel, Translated From The Encyclopaedia of the Philosophical Sciences*. Clarendon Press; 1874.
19. Linehan M. *DBT? Skills Training Manual*. Guilford Publications; 2014.
20. Delaquis CP, Joyce KM, Zalewski M, et al. Dialectical behaviour therapy skills training groups for common mental health disorders: a systematic review and meta-analysis. *J Affect Disord*. 2022;300:305-313. doi:10.1016/j.jad.2021.12.062
21. Harris R. Embracing your demons: an overview of acceptance and commitment therapy. *Psychother Aust*. 2006;12(4):70-76.
22. Hayes SC, Pierson H. Acceptance and commitment therapy. *Encyclopedia of Cognitive Behavior Therapy*, 2005:1-4.
23. Hempel RJ, Booth R, Giblin A, et al. The implementation of RO DBT in clinical practice. *Behav Ther*. 2018;41(3):161-173.
24. Hayes SC, Strosahl KD, Wilson KG. *Acceptance and Commitment Therapy*. Guilford Press; 1999:6.
25. Lynch TR. *The Skills Training Manual for Radically Open Dialectical Behavior Therapy: A Clinician's Guide for Treating Disorders of Overcontrol*. New Harbinger Publications; 2018.
26. Harris R. 2023. A Quick Look at Your Values. https://www.actmindfully.com.au/wp-content/uploads/2019/07/Values_Checklist_-_Russ_Harris.pdf
27. Hayes S. 2023. "Values Writing". https://stevenchayes.com/wp-content/uploads/2019/05/Values-Writing.pdf
28. Hayes S. 2023. " I've got a secret". https://stevenchayes.com/wp-content/uploads/2019/05/Ive-Got-a-Secret.pdf
29. Serowik KL, Khan AJ, LoCurto J, Orsillo SM. The conceptualization and measurement of values: a review of the psychometric properties of measures developed to inform values work with adults. *J Psychopathol Behav Assess*. 2018;40:615-635.
30. Wilson KG, Sandoz EK, Kitchens J, Roberts M. The Valued Living Questionnaire: defining and measuring valued action within a behavioral framework. *Psychol Rec*. 2010;60:249-272.
31. Harris R. 2023. Complete Worksheet for Russ Harris ACT Books. https://www.actmindfully.com.au/upimages/2016_Complete_Worksheets_for_Russ_Harris_ACT_Books.pdf
32. Prevedini AB, Presti G, Rabitti E, Miselli G, Moderato P. Acceptance and commitment therapy (ACT): the foundation of the therapeutic model and an overview of its contribution to the treatment of patients with chronic physical diseases. *G Ital Med Lav Ergon*. 2011;33(1 suppl A):53-63.

33. Belisle J, Dixon MR. Relational behavior and ACT: a dynamic relationship. *Behav Anal Pract*. 2022;15:71-82.
34. Monestès JL, Villatte M. Humans are the selection criterion in psychological science, not "reality": a reply to Herbert and Padovani. *J Contextual Behav Sci*. 2015;4(3):210-211.
35. Polk KL, Schoendorff B, Webster M, Olaz FO. *The Essential Guide to the ACT Matrix: A Step-By-Step Approach to Using the ACT Matrix Model in Clinical Practice*. New Harbinger Publications; 2016.
36. Villatte JL, Vilardaga R, Villatte M, Plumb Vilardaga JC, Atkins DC, Hayes SC. Acceptance and commitment therapy modules: differential impact on treatment processes and outcomes. *Behav Res Ther*. 2016;77:52-61.
37. Wilson KG. *Innovations in Acceptance and Commitment Therapy: Clinical Advancements and Applications in ACT*. New Harbinger Publications; 2020.
38. Levin ME, Twohig MP, Krafft J. *Innovations in Acceptance and Commitment Therapy*, 2020.
39. Lynch TR. *Radically open dialectical behavior therapy: Theory and practice for treating disorders of overcontrol*. New Harbinger Publications; 2018.
40. Center T, Lynch TR. Radically open dialectical behavior therapy: shared features and differences with ACT, DBT, and CFT. *Radic Open*. 2018;41(3):142.
41. Hoyer J, Čolić J, Grübler G, Gloster AT. Valued living before and after CBT. *J Contemp Psychother*. 2020;50:37-45.
42. Hoyer J, Hoefler M, Wuellhorst V. Activity and subsequent depression levels: a causal analysis of behavioural activation group treatment with weekly assessments over 8 weeks. *Clin Psychol Psychother*. 2020;27(3):330-336.
43. Gratz KL, Gunderson JG. Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behav Ther*. 2006;37(1):25-35.
44. Morton J, Snowdon S, Gopold M, Guymer E. Acceptance and commitment therapy group treatment for symptoms of borderline personality disorder: a public sector pilot study. *Cogn Behav Pract*. 2012;19(4):527-544.
45. Zimmerman Michael J, Bradley Ben. Intrinsic vs. extrinsic value. In: Zalta EN, ed. *The Stanford Encyclopedia of Philosophy*. Spring 2019 ed., 2019. https://plato.stanford.edu/archives/spr2019/entries/value-intrinsic-extrinsic/
46. Tjeltveit A. *Ethics and Values in Psychotherapy*. Routledge; 2003.
47. Leaviss J, Uttley L. Psychotherapeutic benefits of compassion-focused therapy: an early systematic review. *Psychol Med*. 2015;45(5):927-945.
48. Cooper R. Ethics and altruism: what constitutes socially responsible design? *Des Manag Rev*. 2005;16(3):10-18.
49. Lynn A. Jansen J. The ethics of altruism in clinical research. *Hastings Cent Rep*. 2009;39(4):26-36.
50. Fava GA, Guidi J. The pursuit of euthymia. *World Psychiatry*. 2020;19(1):40-50.
51. Lützén K, Blom T, Ewalds-Kvist B, Winch S. Moral stress, moral climate and moral sensitivity among psychiatric professionals. *Nurs Ethics*. 2010;17(2):213-224.
52. Mänttäri-van der Kuip M. Conceptualising work-related moral suffering—exploring and refining the concept of moral distress in the context of social work. *Br J Soc Work*. 2020;50(3):741-757.
53. Papazoglou K, Chopko B. The role of moral suffering (moral distress and moral injury) in police compassion fatigue and PTSD: an unexplored topic. *Front Psychol*. 2017;8:1999.
54. Albrecht G, Sartore GM, Connor L, et al. Solastalgia: the distress caused by environmental change. *Australas Psychiatry*. 2007;15(suppl 1):S95-S98.
55. Pihkala P. Anxiety and the ecological crisis: an analysis of eco-anxiety and climate anxiety. *Sustainability*. 2020;12(19):7836.
56. Baudon P, Jachens L. A scoping review of interventions for the treatment of eco-anxiety. *Int J Environ Res Public Health*. 2021;18(18):9636.
57. De Miranda L. Think into the place of the other: the crealectic approach to philosophical health and care. *Int J Philos Pract*. 2021;7(1):89-103.
58. De Miranda L. Five principles of philosophical health for critical times: from hadot to crealectics. *Eidos J Philos Cult*. 2021;5(1):70-89.
59. Gilmore RA, Gilmore R. *Philosophical Health: Wittgenstein's Method in "Philosophical Investigations"*. Lexington Books; 1999.
60. Wittgenstein L. Anscombe GEM, Rhees R, eds. *Philosophical Investigations*. Macmillan; 1953:133.
61. Levy MR, Dignan MB, Shirreffs JH. *Life & Health*. Random House; 1987.
62. Kant I. *Anthropology, History, and Education*. Cambridge University Press; 2007.
63. Hempel R, Vanderbleek E, Lynch TR. Radically open DBT: targeting emotional loneliness in anorexia nervosa. *Eat Disord*. 2018;26(1):92-104.
64. Shrestha AK. Positive psychology: evolution, philosophical foundations, and present growth. *Indian J Posit Psychol*. 2016;7(4):460.
65. Waterman AS, ed. *The Best Within Us: Positive Psychology Perspectives on Eudaimonia*. American Psychological Association; 2013:303.
66. Lee Duckworth A, Steen TA, Seligman MEP. Positive psychology in clinical practice. *Annu Rev Clin Psychol*. 2005;1:629-651.
67. Meyers MC, van Woerkom M, Bakker AB. The added value of the positive: a literature review of positive psychology interventions in organizations. *Eur J Work Organ Psychol*. 2013;22(5):618-632.
68. Hervás G. The limits of positive interventions. *Pap Psicól Psychol Pap*. 2017;37(1):42.
69. Held BS. The negative side of positive psychology. *J Humanist Psychol*. 2004;44(1):9-46.
70. Bolier L, Haverman M, Westerhof GJ, Riper H, Smit F, Bohlmeijer E. Positive psychology interventions: a meta-analysis of randomized controlled studies. *BMC Public Health*. 2013;13(1):119.
71. Valdivia-Salas S, Lombas AS, Salvador S, López-Crespo G. Psychological inflexibility and valuing happiness: dangerous liaisons. *Front Psychol*. 2022;13:13.
72. Bojanowska A, Urbańska B. Individual values and well-being: the moderating role of personality traits. *Int J Psychol*. 2021;56(5):698-709.
73. Hunot V, Moore TH, Caldwell DM, et al. 'Third wave' cognitive and behavioural therapies versus other psychological therapies for depression. *Cochrane Database Syst Rev*. 2013(10):CD008704.
74. Öst LG. Efficacy of the third wave of behavioral therapies: a systematic review and meta-analysis. *Behav Res Ther*. 2008;46(3):296-321.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Martin S. Using values in cognitive and behavioral therapy: a bridge back to philosophy. *J Eval Clin Pract*. 2023;29:1189-1195. doi:10.1111/jep.13872