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**Attitudes and applications of chairwork amongst CBT therapists: A preliminary survey.**

**Abstract**

Chairwork refers to a collection of experiential interventions which utilise chairs, their positioning, movement, and dialogue to facilitate therapeutic change. Chair-based methods are utilised in several models of psychotherapy, including cognitive behavioural therapy (CBT). However, little is known about cognitive behavioural therapists' use and attitudes towards chairwork. A mixed methods survey was conducted of 102 therapists who provided CBT. Overall, training in chairwork was weak amongst CBT therapists (35%). Quantitative results indicated that most therapists perceived chairwork to be clinically effective and consistent with the cognitive behavioural model, but did not feel competent using these methods. Perceived competence was highest amongst therapists who had been trained in chairwork and practised it frequently, but was unrelated to CBT accreditation or clinical experience. Qualitative feedback identified a number of factors that encouraged the use of chairwork (e.g., overcoming limitations associated with verbal restructuring methods), as well as inhibitors (e.g., therapist anxiety and limited access to training). These preliminary findings highlight a need for further research relating to cognitive behavioural chairwork and suggest that increased training in experiential interventions could go some way towards improving outcomes in CBT.

## **Introduction**

Cognitive behavioural therapy (CBT) is an effective, empirically-supported psychotherapy, which is recommended for the treatment of a range of emotional disorders (Butler, Champan, Forman, & Beck, 2006; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). While CBT incorporates a variety of therapeutic techniques to promote cognitive-affective change, experiential methods are regarded as being amongst the most powerful (Greenberger & Padesky, 1995; Wells, 1997; Young, Klosko, & Weishaar, 2003). Cognitive theory provides insights into why this may be the case. Dual process models such as Teasdale and Barnard's (1993) theory of Interacting Cognitive Subsystems (ICS) propose that information processing is governed by two subsystems: a propositional code which is concerned with factual, language-correspondent "head-level" beliefs, and a "implicational" code which is concerned with implicit, "heart-level" beliefs which tend to manifest as felt-senses. Similarly, Epstein's (2014) Cognitive-Experiential model (CEM) distinguishes between a non-verbal, holistic, and emotion-driven experiential information processing system, and a rational system associated with effortful, analytic, and verbal information subsystem. The implication of dual processing models has been that modifying affect-laden implicational/experiential knowledge is preferentially achieved through experiential interventions "in which new or modified models are created" (Teasdale, 1997, p.90). Consistent with this position, preliminary research suggests that experiential methods such as behavioural experimentation and imagery may be more effective than verbal restructuring in generating cognitive-affective change (Bennett-Levy, 2003; Hyett et al., 2018).

Whilst experiential interventions are often used in CBT, few studies have explored the therapeutic applications of 'chairwork': a collection of procedures which utilise chairs, their positioning, and movement in order to facilitate imaginal dialogues between parts of the self ('internal dialogues'), other individuals ('external dialogues'), and symbolic representations

(‘fantasy dialogues’). Archetypal forms of chairwork include empty-chair dialogues with absent individuals, multi-chair dialogues which involve speaking from two or more internal perspectives, and role-playing procedures in which interpersonal events are recreated or new behaviours are rehearsed (Pugh, 2019b). Originating from psychodrama (Moreno, 1987) and popularised by gestalt therapy (Perls, 1973), chairwork is used for many purposes in CBT including cognitive restructuring, behavioural skills training, and, to a lesser degree, emotional regulation (Pugh, 2019a,b). Historically, cognitive therapy has viewed chairwork as a ‘second-line’ intervention for resistant cognitions or when verbal restructuring techniques fail (Beck, 1995; Ellis, 2001). In contrast, chairwork represents a more central method in several CBT-allied models of therapy including schema therapy (Young et al., 2003), compassion-focused therapy (Gilbert, 2010), and trial-based cognitive therapy (de Oliveira, 2015).

Research examining the effectiveness of cognitive behavioural chairwork are limited, although existing findings are encouraging (Cromarty & Marks, 1995; Lipsky, Kassinove, & Miller, 1980; Newman & Shrubbs, 1994). For example, studies indicate that the trial-based role-play (de Oliveira, 2015) is an effective method for modifying negative core beliefs and ameliorating associated distress (de Oliveira 2008; de Oliveira et al. 2012a). Moreover, trial-based role-playing appears to be advantageous in reducing fears of negative evaluation and avoidance amongst individuals with social phobia when compared to use of automatic thought records and positive data logging (de Oliveira et al., 2012b). Qualitative studies have also highlighted the memorability and ‘felt truth’ of changes brought about through chairwork (Bell, Montague, Elander, & Gilbert, 2019; Chadwick, 2003). In terms of behaviour change, behavioural rehearsal through role-play has proved to be a highly effective method for establishing new interpersonal skills, particularly assertiveness (Speed, Goldstein, & Goldfried, 2018).

Despite its supposed effectiveness, competency frameworks have made limited reference to the applications of chairwork in CBT. For example, Roth & Pilling (2007) discuss role-playing only in the context of modifying core beliefs<sup>1</sup>, while process-based frameworks limit chairwork to cognitive reappraisal (Arntz, 2018, Wenzel, 2018) and interpersonal skills training (Mueser, 2018). This leads us to hypothesise that chairwork is used infrequently by cognitive behavioural therapists. Other research has highlighted other factors which obstruct the use of evocative interventions including therapist anxiety, negative attitudes, and lack of specialist training (Bell, Mackie, & Bennett-Levy, 2014; Harned et al., 2013; Waller, Stringer, & Meyer, 2012). In addition, little is known about therapists' attitudes towards chairwork, including its perceived utility and compatibility with CBT. Such an understanding would help gauge what place chairwork holds in cognitive behavioural practice, as well as potential training needs amongst therapists.

The aim of this exploratory practitioner survey was to provide data relating to cognitive behavioural therapists' attitudes and experiences of chairwork. The specific aims were to survey CBT therapists' (a) training, competency, and use of chairwork; (b) attitudes towards chairwork in terms of efficacy, relevance, and compatibility; and (c) the experience of delivering chairwork within CBT. The study also aimed to determine whether CBT therapists' use of chairwork varied according to their training backgrounds.

## **Method**

### **Design**

A cross-sectional design was used, using a self-report questionnaire which was completed by hand. A mixed methods approach was employed to provide a comprehensive picture of therapists' attitudes and experiences of chairwork, as well as to generate hypotheses

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<sup>1</sup> Role-playing techniques are paid greater attention in problem-specific competencies in CBT, most notably stress-inoculation training, although chairwork is not included as broader therapeutic method.

about its applications in CBT. Equal priority was given to both types of data.

### **Participants and procedure**

The participants were a convenience sample of qualified therapists working in the UK. Participants were recruited at training events facilitated by the first two authors over a twelve month period. Topics for workshops were either applications of chairwork in CBT or introductions to compassion-focused therapy. Survey questionnaires were completed at the start of training events. The clinicians consisted of 88 women and 14 men who routinely delivered CBT. Participants had a mean age of 42.5 years ( $SD = 10.3$ ; range = 24-71) and reported a mean amount of time delivering CBT of 8.18 years ( $SD = 5.67$ ; range = 0.25-30.0). Their mean amount of time delivering CBT was reported as 15.3 hours per week ( $SD = 7.63$ ; range = 1-40). Sixty-eight were accredited CBT clinicians, 10 were accredited CBT supervisors, and three were accredited CBT trainers.

### **Survey questionnaire**

The survey questionnaire was designed specifically for this study. The questionnaire was constructed to assess clinicians' attitudes towards chairwork in the context of CBT and personal experiences of using these techniques. The questionnaire also contained basic demographic data items and items regarding participants' professional background (see Results section). The design process consisted of developing, reviewing, and refining study-specific items through discussion amongst the research team.

The final survey consisted of a total of five close-ended items and seven open-ended items. Closed-ended items consisted of the following questions, which were coded on a five point Likert scale: self-rated competency using chairwork in the context of CBT (1 = not competent, 5 = very competent); frequency of use of chairwork in CBT (1 = never, 5 = very frequently); perceived compatibility of chairwork and CBT (1 = not at all compatible, 6 = very compatible); perceived effectiveness of chairwork (1 = very ineffective, 5 = very effective);

and the perceived value and importance of chairwork in CBT (1 = not important / valuable, 5 = very important / valuable). The remaining seven open-ended item invited participants to describe personal experiences of applying chairwork within their cognitive behavioural practice (Table 1).

### **Data analysis**

Quantitative data was analysed using SPSS software. Qualitative responses were typed and collated. The resultant data was analysed using Braun and Clarke's (2006) six-stage thematic analysis. This involved an inductive coding of the data, identifying patterns of meaning and significance, and producing a set of initial themes. These were then refined to produce a table of superordinate themes. In line with quality guidelines for qualitative research (e.g. Elliott, Fischer, & Rennie, 1999), the main analysis was carried out by one author (TB) and independently audited by a second author (MP) to ensure the credibility of superordinate themes and their grounding in the raw data. Differences in interpretation were negotiated to produce the final set of themes.

## **Results**

### **Quantitative analysis**

#### ***Clinician characteristics***

36 clinicians (35%) had received formal training in chairwork and 49 (48%) had been trained in CBT-allied therapies most associated with the use of chairwork (e.g. schema therapy and compassion-focused therapy), though they had not necessarily been exposed to chairwork in those trainings.

#### ***Use and perceived value of chairwork***

Table 1 shows the clinicians' perceptions of their own competence and frequency of use of chairwork, and their views of its compatibility with CBT, relevance to cognitive behavioural practice, and its effectiveness. The majority rated their own chairwork skills as

weak to moderate, and did not use it often. However, most regarded it as an effective intervention, compatible with CBT, which makes a significant contribution to cognitive behavioural practice.

### ***Factors associated with opinions regarding chairwork***

The association of general CBT accreditation with perceived competence in using chairwork was tested using t-tests. Those clinicians who had CBT accreditation: did not feel more competent in using chairwork (accredited:  $M = 2.23$ ,  $SD = 0.92$ ; not accredited:  $M = 2.35$ ,  $SD = 0.99$ ); did not use chairwork more often (accredited:  $M = 2.23$ ,  $SD = 0.92$ ; not accredited:  $M = 2.35$ ,  $SD = 0.99$ ); did not feel that chairwork was more CBT-compatible (accredited:  $M = 4.06$ ,  $SD = 0.86$ ; not accredited:  $M = 4.40$ ,  $SD = 0.60$ ); did not feel that chairwork was more effective (accredited:  $M = 4.30$ ,  $SD = 0.68$ ; not accredited:  $M = 4.21$ ,  $SD = 0.54$ ); did not feel that chairwork made more of a contribution (accredited:  $M = 4.10$ ,  $SD = 0.75$ ; not accredited:  $M = 4.16$ ,  $SD = 0.60$ ); and did not have a more positive attitude to chairwork (accredited:  $M = 12.6$ ,  $SD = 1.93$ ; not accredited:  $M = 12.7$ ,  $SD = 1.28$ ). None of these differences was significantly different ( $t < 1.70$ ; *NS* in all cases).

	<b>Accredited CBT therapist?</b>		<b>t-test</b>	
	<b>No</b>	<b>Yes</b>	<b>t</b>	<b>P</b>
Competence in using chairwork	2.35	2.23		<i>NS</i>
(SD)	(0.99)	(0.92)		
Frequency of use of chairwork	2.35	2.23		<i>NS</i>
(SD)	(0.99)	(0.92)		
CBT-compatibility of chairwork	4.40	4.06		<i>NS</i>
(SD)	(0.60)	(0.86)		
Effectiveness of chairwork	4.21	4.30		<i>NS</i>
(SD)	(0.54)	(0.68)		
Contribution of chairwork	4.16	4.10		<i>NS</i>
(SD)	(0.60)	(0.75)		
Positive attitude to chairwork	12.7	12.6		<i>NS</i>
(SD)	(1.28)	(1.93)		
	<b>Training</b>		<b>t-test</b>	
	<b>No</b>	<b>Yes</b>	<b>t</b>	<b>P</b>
Chairwork	1.99	2.75	4.14	.001
(SD)	(0.81)	(0.94)		
Chairwork-compatible approaches	1.94	2.59	3.73	.001
(SD)	(0.96)	(0.78)		



In contrast, clinicians who had received formal training in chairwork perceived themselves as more competent in its application (trained:  $M = 2.75$ ,  $SD = 0.94$ ; not trained:  $M = 1.99$ ,  $SD = 0.81$ ;  $t = 4.14$ ,  $P < .001$ ). Similarly, generic training in chairwork-compatible therapies was associated with feeling more competent in applying it (trained:  $M = 2.59$ ,  $SD = 0.96$ ; not trained:  $M = 1.94$ ,  $SD = 0.78$ ;  $t = 3.73$ ,  $P < .001$ ).

Frequency of use of chairwork was correlated (Pearson's  $r$ ) with perceived competence, to determine whether the extent of use of this method was linked to the perceived ability to deliver it well. This correlation was strongly significant ( $r = .671$ ,  $P < .001$ ). Finally, the temporal variables (age, length of time providing CBT, number of hours per week delivering CBT) were associated with the variables detailed in Table 2 (levels of competence, etc.) and with positive attitudes to chairwork. Pearson's  $r$  was used, with a Bonferroni correction to reduce the risk of Type 1 error. None of these correlations approached significance ( $r < .25$ ,  $NS$  in all cases). This pattern of correlations indicates that clinician experience and frequency of use leads clinicians to view themselves as being more skilled in delivering chairwork, but that level of use and clinical caseload do not result in such perceived skills.

### **Qualitative analysis**

The analysis of the qualitative data produced four interacting themes: 'connecting the head and heart'; 'fears of client reactions'; 'confidence and competence'; and 'from self-criticism to compassion'.

#### ***Theme 1: Connecting to emotion***

Therapists predominant reason for using chairwork was to encourage clients to acknowledge, experience, and articulate their emotions. Participants were more likely to consider chairwork when clients 'struggle to connect' to their feelings or experienced a disjunction between 'head' versus 'heart' processing:

*'I tend to use it more when clients become stuck connecting to an incident or when they can 'understand' the rationality, however cannot 'feel' it'.*

Chairwork was associated with the deepening of emotional experiencing and contrasted with verbal interventions associated with logical challenging. 'Embodied learning' and 'body work' (the use of gesture, posture and vocalizations) were identified as key factors in making chairwork emotive, immersive, and effective.

*'[Chairwork] seems to promise greater effects through dramatization and intense emotional response as opposed to purely cognitive work'*

*'To move from the head into the body, to make things more real'.*

Working with heightened levels of emotion was often described as 'empowering', increasing clients' agency related to their feelings and their expression. Participants also identified the benefit of using chairwork to reverse and target emotional avoidance or 'blocking' in session. Specific forms of chairwork were also valued for allowing emotions to be personified, embodied and addressed directly. Notably, chairwork was associated with facilitating healthy expressions of anger.

[Quote?]

## ***Theme 2: Concerns about client reactions***

Despite highlighting the benefits of activating emotion, participants were concerned about overwhelming or dysregulating clients due to the emotional intensity of the method.

*'I think they generally find it very powerful, but also highly distressing, sensitivity and plenty of time are needed. As above I think their fear makes them find it quite difficult to let go'.*

Participants feared making their clients 'worse' and 'causing more harm than good' through potential destabilisation or disengagement. This consideration interacted with service factors, such as the limited time afforded to developing soothing/grounding skills in short-term work. The presence of a strong therapeutic relationship was deemed to be key factor in

mediating and mitigating the potential for causing distress and was frequently identified as an important consideration when deciding to use the approach.

[Quote]

Concerns about client reactions also centered on the potential for chairwork to generate self-consciousness, embarrassment, and shame. Participants suggested the some clients might ‘feel too exposed’, perceive the exercise as ‘child-like’ or ‘weird’, or associate the process with acting and pretense:

*‘If a client sees it as acting and therefore not real for them. If they’re not open to working with/making space for some resistance about doing chairwork, i.e. willing to experiment with it.’*

Client ‘skepticism’ or lack of ‘openness’ to experiential methods was frequently cited as reasons not to use chairwork. Certain presentations were also avoided by some therapists, such as trauma, personality disorder, or severe low mood (out of concern for de-stabilization or the escalation of risk). Clinicians were also concerned that clients might become absorbed or ‘stuck’ in specific roles or emotions.

[Quote].

Despite these concerns, the majority of participants felt that such reactions would be short-lived, part of the therapeutic process (‘deepening the experience of therapy’), and ultimately helpful or ‘potentially revolutionary’.

### ***Theme 3: Confidence and competence***

Participants’ fears of client dysregulation were shaped by doubts about their own confidence and competence using chairwork, sometimes leading to avoidance of these interventions. Doubts were focused on technical ability, decision-making regarding when and where to use chairwork, and how to manage blocks and other difficulties arising during enactments.

*'Concerned I may 'get it wrong'. Concerned I might misuse it – clients go home feeling very confused'*

*'Messing it up. Getting stuck and not knowing how to guide the role play next.'*

Other therapists felt like an 'imposter' delivering a technique that was alien to them ('I was never very good at acting'). In addition, difficulties 'selling' the approach to clients and negative experiences using chairwork in the past were also identified as factors reducing its use.

#### [Quote]

Therapists' anxieties and doubts relating to chairwork were linked to a lack of coverage in their core-training or limited access to formal chairwork training. Participants also identified a professional 'stigma' linked to chairwork insofar as its supposed deviation from established models and protocols. The lack of supervisor interest and competence in chairwork was deemed to be an important factor limiting use of chairwork.

*'I suppose not being able to receive adequate supervision for when difficult emotions come up'*

#### **Theme 4: From self-criticism to compassion**

A recurrent theme was using chairwork to both explore and target 'self-to-self relating', specifically self-criticism and self-compassion.

*'I thought it helped reinforce a different style of self-talk. Moving chairs is likely to distinguish critical thinking from compassionate thinking more easily.'*

*'For highly self-critical people with lots of shame. To help people learn alternative ways of self-to-self relating'*

Participants highlighted the therapeutic value of using chairwork to differentiate internal 'voices', concretise self-self dialogues, and 'de-centre' from self-critical cognitions. In addition, chairwork helped facilitate self-compassion by developing new 'perspectives' and self-directed 'empathy', as well as new curative 'feelings' which ameliorated self-criticism.

Participants frequently considered chairwork when working with low self-esteem and suggested its use was particularly helpful with negative core beliefs. Notably, compassion-focused therapy was often therapists' only exposure to chairwork.

### **Discussion**

Whilst CBT is undoubtedly efficacious, treatment outcomes are not always satisfactory (Hudson et al., 2015; Westen & Morrison, 2001). Driven by the need to develop more effective interventions, experiential methods have recently experienced renewed interest in CBT (Borkovec, Newman, & Castonguay, 2003; Salusman, Ji, & McEvoy, 2019). Of these, cognitive behavioural forms of chairwork are perhaps most enigmatic and poorly understood (Pugh, 2019a).

This study explored CBT therapists' attitudes and experiences of chairwork. In summary, CBT therapists rated their competence and use of chairwork as low. Despite this, clinicians regarded chairwork as an effective and CBT-compatible therapeutic method. Pioneering CBT manuals have emphasised the utility of chairwork (Beck & Emery, 1985; Beck, Rush, Shaw, & Emery, 1979; Beck, 1995; Young, 1990), although its application in practice appears to be sparse. Consistent with therapist training research (Beidas & Kendall, 2010; Rakovshik & McManus, 2010), the quantitative results indicated that clinicians who had undertaken training in chairwork or therapeutic models which emphasised its use (e.g. schema therapy and compassion-focused therapy) perceived themselves as more competent and utilised these procedures more frequently. However, this was not the case for accredited CBT therapists, irrespective of temporal factors (e.g. longer durations of experience). Competency frameworks for delivering CBT indicate that chairwork and, relatedly, role-play are useful in treating certain disorders (Hayes & Hoffman, 2018; Roth & Pilling, 2007), although their importance is underemphasised compared to other techniques (e.g. cognitive reappraisal and behavioural experimentation).

The qualitative findings contextualised CBT therapists' attitudes towards chairwork. Key foci for chairwork included emotional processing and cognitive modification, and tended to be used when 'traditional' cognitive behavioural methods proved insufficient. While research suggests that chairwork is an effective method for modifying maladaptive thoughts and feelings (e.g. de Oliveira, 2008; Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995), support for chairwork as behaviour change method is as equally strong (Lazarus, 1966; Sanchez, Lewisohn, & Larson, 1980). It is unfortunate, then, that use of enactive behavioural methods appears to be declining amongst therapists (Speed, Goldstein, & Goldfried, 2018). The results of this study suggest that more could be done to promote the use of modelling and behavioural rehearsal through chairwork amongst CBT therapists.

The qualitative findings indicated that CBT therapists' use of chairwork was informed by overlapping conceptual frameworks: 'embodied' approaches to cognitive-affective change and the need to achieve 'head-level' and 'heart-level' belief change. Beginning with the former, embodied approaches to CBT emphasise the reciprocal interactions between bodily events (e.g. posture, gesture, and motion) and cognitive-affective experience (Hauke, Lohr, & Pietrzak, 2016). Research has supported this hypothesis, demonstrating that changes in bodily processes influence mood (Michalak, Burg, & Heidenreich, 2012), while adaptive changes in thought and feeling can be 'anchored' to physiology through action (Bell, Montague, Elander, & Gilbert, 2020). Similarly, ICS has highlighted the role of bodily inputs in the maintenance of negative emotional states and underlying implicational knowledge (Teadale & Barnard, 1993). In order to bring about implicational ('heart-level') change, ICS recommends use of multisensory interventions rather than analytic techniques which primarily influence rational (i.e. propositional) processes. Thus, it appears that CBT therapists use of chairwork is broadly consistent with theoretical literature.

Alongside contextual factors (e.g. limited experience and access to training), therapist-specific variables also influenced their attitudes and practice. In particular, therapists were often fearful of clients' negative reactions to chairwork. Therapist anxiety has been shown to obstruct the use of therapeutic procedures, particularly those which are evocative and demanding (Harned, Dimeff, Woodcock, & Contreras, 2013). For example, anxious clinicians tend to favour talk-based strategies (e.g. verbal restructuring) over active interventions such as exposure (Levita, Salas Duhne, Girling, & Waller, 2016; Parker & Waller, 2019). Enactive techniques such as chairwork require both creativity and spontaneity (Moreno, 1987), which can challenge clinicians who favour certainty (Levita et al., 2019). Training strategies based on dual-processing theory suggest that simulated therapy exercises are effective both in terms of enhancing technical competence and violating therapists' expectations of harm through direct experience of interventions (Farrell, Deacon, Dixon, & Lickel, 2013). Accordingly, learning chairwork through self-practice and self-reflection may offer a particularly valuable medium for building therapists' confidence and skill (Bennett-Levy, Turner, Beaty, Smith, Paterson, & Farmer, 2001).

This is the first study to survey therapists' experiences of chairwork and requires substantial development. Given that the participants were a convenience sample, it is unclear how far these findings generalise. In order to avoid what could be an overly optimistic picture of cognitive behavioural chairwork, replication studies are needed using a larger and more representative sample. The study also utilised a non-standardised survey questionnaire which relied on self-reported practice. Moreover, the construct validity of survey items was assumed although this is questionable. Observational studies would provide more reliable data regarding CBT therapists' application and understanding of chairwork. Finally, future studies should establish the reliability and validity of clinicians' definitions of chairwork. For example, do CBT therapists regard role-play as form of chairwork or a distinct therapeutic method?

In summary, our findings provide a baseline understanding of CBT therapists' attitudes and applications of chairwork. In terms of future research, an extension of this study would be to examine client attitudes and experiences of chairwork in CBT (Bell et al., 2020). There is also a need to establish the efficacy of cognitive behavioural chairwork and its change mechanisms. The qualitative results also present a variety of hypotheses. For example, to what extent does therapist anxiety affect the use of chairwork, and what are mediators and moderators of this relationship (e.g. fear of clients' expressed emotion)? Finally, we must not assume that CBT therapists' limited use of chairwork is 'bad' without better understanding for whom these interventions work, with which presenting difficulties, and at what point(s) in treatment.

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Table 1

*Open-ended questionnaire items*

1. When do you tend to use chairwork techniques in a course of CBT, if at all? Please give details.
2. Are there any factors that make you likely to use chairwork in CBT? Please explain your answer.
3. Are there any factors that make you less likely to use chairwork in CBT? Please explain your answer.
4. Why might you use chairwork techniques (rather than other techniques) in a course of CBT?
5. Do you have any concerns or worries about using chairwork?
6. How do you think clients experience chairwork in CBT, or might/could experience chairwork?

Table 2

*Clinicians' reports of their skills and their perceptions of the value of chairwork.*

<b>Self-rating</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Competence	22	45	24	12	0
Frequency	35	30	30	7	1
Compatibility with CBT	0	3	19	40	38
Effectiveness	0	1	7	50	35
Value and importance	0	1	17	49	30