PART III

The Cognitive-Behavioural Tradition

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Cognitive Therapy

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1 HISTORICAL CONTEXT AND DEVELOPMENT

During the middle years of this century psychology was dominated by the twin edifices of behaviourism and psychoanalysis. On the one hand, the individual's internal world was unimportant and his or her actions were determined by environmental events. On the other hand, the internal world was all important but its workings were unconscious and accessible only with the help of a trained guide. The thoughts which most people regarded as central to their experience of everyday life were seen by both schools as peripheral. There were, however, some lone voices that defended the individual as a conscious agent. George Kelly emphasised how the person seeks gives meaning to the world, and suggested that each of us constructs our own reality through a process of experimentation. Albert Ellis drew attention to the role of irrational beliefs in neurotic disorders and developed rational-emotive therapy (RET) to change these beliefs systematically.

The study of the mental processes, which intervene between stimulus and response, is termed 'cognitive psychology'. This includes a wide range of activities including thinking, remembering and perceiving. In the 1970s psychology underwent a 'cognitive revolution' as it moved from the 'first wave' of behavioural therapies to a 'second wave' of cognitive behaviourism. Psychologists began to investigate how cognitions could be treated as behaviours in their own right, and so might be conditioned or deconditioned. Bandura showed that it was possible to understand the phenomenon of modelling from a cognitive rather than strictly behaviourist perspective, and Mahoney drew attention to the significance of cognitive

processes such as expectation and attribution in conditioning. This increasing interest in cognition led to the development of various cognitive-behavioural therapies. Although they all have slightly different theoretical perspectives they share common assumptions and it is often difficult to distinguish them in terms of the techniques used in clinical practice. Of these the most influential have been Ellis's rational-emotive therapy (now known as rational emotive behaviour therapy – see Chapter 11) and Beck's cognitive therapy. Ellis aims to make the client aware of his or her irrational beliefs and how they lead to maladaptive emotional states. He emphasises cognitive processes that are 'evaluative' rather than 'inferential'. If, for example, a client reported that she felt depressed when a friend ignored her in the street, rather than asking her if there were any alternative explanation (e.g. her friend was preoccupied and did not notice her) Ellis would home in immediately on the evaluative belief underlying her reaction 'I must be liked by people').

Beck, like Ellis, was originally an analyst who became disillusioned with the orthodox Freudian tradition. His research into depression led him to believe that this condition was associated with a form of 'thought disorder', in which the depressed person distorted incoming information in a negative way. The therapy derived from Beck's cognitive model focused on teaching clients to learn to identify and modify their dysfunctional thought processes. Underlying these negative thoughts are beliefs that need to be restructured to prevent further depression. In 1977 Beck's group published the first outcome study comparing cognitive therapy with pharmacotherapy in depressed clients. This generated great interest: first, because previous studies had shown psychotherapy to be less effective than drug treatment with this group of clients; and second, because psychologists were already becoming interested in cognitive approaches. From its origins in the USA cognitive therapy has become increasingly popular across the world. We now have the emergence of a 'third wave' of CBT, which is challenging the conventional wisdom. However, the fundamentals of the cognitive approach as outlined many years ago in Beck's seminal *Cognitive Therapy and the Emotional Disorders* (Beck, 1976) remains the cornerstone of most CBT practised today and has the strongest evidence base. In this chapter the generic model of cognitive therapy will be the main focus, with particular reference to depression and anxiety disorders.

2 THEORETICAL ASSUMPTIONS

2.1 Image of the person

Cognitive therapy makes a number of assumptions about the nature of the human individual:

1. The person is an active agent who interacts with his or her world.
2. This interaction takes place through the interpretations and evaluations the person makes about his or her environment.
3. The results of the 'cognitive' processes are thought to be accessible to consciousness in the form of thoughts and images, and so the person has the potential to change them.

Emotions and behaviour are mediated by cognitive processes. This distinguishes cognitive therapy from the extreme forms of behaviour therapy, which sees the organism as a black box: what goes on inside the box is of little consequence. It also distinguishes it from psychoanalysis, which gives prime importance to unconscious rather than conscious meanings. According to Beck:

> 'The specific content of the interpretation of an event leads to a specific emotional response ... depending on the kind of interpretation a person makes, he will feel glad, sad, scared, or angry – or he may have no particular emotional reaction at all. (Beck, 1976: 51–2)

The behavioural response will also depend upon the interpretation made. An important concept in Beck's view of normal and abnormal behaviour is the idea of the 'personal domain'. The personal domain is the conglomeration of real and abstract things that are important to us: our family, possessions, health, status, values and goals. Each of us has a different set of items in our personal domain; the more an event impinges on our domain the stronger our emotional reaction is likely to be. The meaning we give to a situation will be determined by the mental set we bring to it. We need rules or guidelines to allow us to make educated guesses about what is likely to happen next. If we did not have an internalised rule that we should stop at red traffic lights, our insurance bills would be considerably higher. Some of these assumptions about the world are shared, but others are intensely personal and idiosyncratic. The hypothetical cognitive structures that guide and direct our thought processes are called 'schemata'. A schema is a template which allows us to filter out unwanted information, attend to important aspects of the environment and relate new information to previous knowledge and memories (Kovacs and Beck, 1978). In areas we know well we have well-developed schemata (e.g. for driving a car, or how to behave at a social gathering), whereas in new situations schemata will be less well developed.

2.2 Conceptualisation of psychological disturbance and health

2.2.1 Psychological disturbance

In emotional disturbance information-processing is biased in a negative distorted way: people revert to more primitive thinking which prevents them functioning as effective problem-solvers (Beck et al., 1979: 15). This thinking tends to be global, absolute and judgmental. A depressed person who is not successful at a job interview would label herself as a total failure, conclude that it was entirely her own fault that she did not get the job, and ruminate about the interview, focusing on everything that went wrong without thinking about any of the positive factors. Beck (1976) identifies 'logical errors' which characterise the thinking in psychological disorders. Table 10.1 summarises some of the common logical errors.

Building on this work on depression, cognitive therapists have been mapping the cognitive abnormalities seen in the various psychiatric disorders. In depression there is a negative view

Table 10.1 Cognitive distortions

1. Arbitrary inference refers to the process of drawing a conclusion from absent or even contradictory evidence. For instance, you pass a friend on the other side of the street and she does not wave to you. You think 'She's ignoring me. She doesn't want to know me.'
2. Selective abstraction occurs when we focus on certain aspects of a situation but ignore others. For instance in health anxiety the person attends to minor twinges and aches and takes them out of context.
3. Over-generalisation is the tendency to conclude general and global conclusions from a single incident. For instance, a single failed job interview triggers the thoughts, 'I'm useless. It's hopeless. I'll never get a job.'
4. Magnification and minimisation refers to the tendency to exaggerate the size or importance of negative evidence and minimise positive. In depression we maximise signs of our inadequacy and minimise and disqualify signs of our competence.
5. Personalisation is the automatic assumption that an event is caused by or relevant to ourselves. For instance, if you hear your friend's laughing you assume they are laughing about you.
6. All or nothing thinking is thinking in dichotomous or black and white terms, such as 'If I'm not a total success I must be a complete failure; people must be totally loyal or I can't trust them at all.'

of the self, the world and the future. In anxiety the cognitive distortions involve an overestimation of major physical or social threat and an underestimation of the individual's ability to cope with the threat. Anxious clients selectively attend to threat cues. More specific models of certain types of anxiety disorder have been proposed. Clark's model of panic emphasises the way in which catastrophic misinterpretations of bodily symptoms create a vicious circle of anxiety leading to more bodily sensations and more panic. Salkovskis and Warwick adapted this model for hypochondriasis: the hypochondriac misinterprets innocuous bodily sensations such as headache, twinges, etc. as signs of chronic life-threatening illness. Each of these diagnostic groups filters information in a slightly different way.

The conscious products of this biased processing are 'negative automatic thoughts'. These are spontaneous thoughts or images which seem plausible, but are in fact unrealistic. In emotional disorders these become frequent and severe. For instance, an anxious person may think 'I can't cope. Something terrible is going to happen.' A depressed person may ruminate about his failures, thinking 'I'm useless, I never do anything right.' The person's behaviour will be consistent with these thoughts.

2.2.2 Psychological health

Psychological health is characterised by the ability to process information in a relatively accurate and flexible manner. Beck suggests that we are all capable of functioning as rational problem-solvers at least some of the time. Psychological health requires us to be able to use the skills of reality-testing to solve personal problems as they occur. Underlying this is a set of rules about the world that are sufficiently consistent to allow us to predict what will happen in the future, but also flexible enough to allow changes on the basis of new information. The distinction between psychological health and disturbance is not a rigid one. The same cognitive processes occur in both: we tend to interpret reality to support or schemata. This means that in psychological health we have a slightly positive bias about ourselves, the world and the future.

2.3 Acquisition of psychological disturbance

Beck considers that there are many factors which predispose an individual to emotional disturbance including genetic predisposition, physical disease, developmental traumas suggesting a much more complex aetiology for emotional disorders than the simplistic notion that cognitions cause emotions. Maladaptive schemata are the main cognitive vulnerability factors. Early learning experiences, traumas and chronic stresses lead to beliefs and attitudes that make a person vulnerable to psychological disturbance. Someone who has a serious illness as a child and is overprotected by his parents may develop a core belief that he is frail and vulnerable and needs to be supported by others to survive. Someone who is continually criticised for making small mistakes may believe that she must get everything she does completely right. These beliefs are the way the person makes sense of the world by developing ideas about how the world does, or should, operate. The more rigid, judgmental and absolute these beliefs become, the more likely they are to cause problems. Examples of beliefs that predispose to anxiety include:

'Any strange situation should be regarded as dangerous.'

'My safety depends on always being prepared for possible danger.'

'I have to be in control of myself at all times.'

Examples of beliefs that predispose to depression include:

'I can only he happy if I am totally successful.'

'I need to be loved in order to be happy.'

'I must never make a mistake.'

When a relevant event occurs they are activated and become the primary mode of processing. For instance, because of early childhood experiences a woman may believe that she needs to be loved in order to survive. While she is in a relationship this belief may not be salient. But if she is rejected by her lover it acts as a premise to the syllogism:

'I need to be loved in order to survive.' 'X has left me.' 'Therefore I cannot survive.'

Cognitive therapy aims not only to correct faulty information-processing but also to modify assumptions and so reduce vulnerability to further psychological disturbance.

2.4 Perpetuation of psychological disturbance

2.4.1 Intrapersonal mechanisms

Biased information-processing explains how information contrary to the client's schema is filtered out or manipulated to make it consistent with her belief system. This is commonly seen in depression, where positive information (e.g. past achievement) is repeatedly disqualified.

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The depressed person will say that past successes were due to luck, or to people helping. In anxiety there is an underlying bias towards attending to threat cues in the environment and interpreting benign situations as dangerous.

Behaviour consistent with dysfunctional beliefs also helps to maintain negative emotions. An example of this can be seen in dog phobia, where *avoidance* of a feared stimulus (dogs) prevents the person from learning that not all dogs are dangerous. A more subtle form of avoidance occurs when we engage in a *safety seeking behaviour* while in a threatening situation. The catastrophic misinterpretation of physical symptoms in panic disorder causes a spiral of anxiety, e.g. breathlessness, triggers the thought 'I'm suffocating. I'm going to die' with consequent focus of attention on breathing, increased anxiety and worsening symptoms. The safety behaviour might be to take deeper, faster breaths, which leads to hyperventilation and exacerbation of the panic. After the event one might expect the person to realise that their fear was misplaced, but two factors can come into play the stop this new learning occurring: firstly they may avoid situations where they have had a panic attack, and secondly they may come to the conclusion that the only thing that saved them from suffocation was taking in deep breaths. It is usually helpful to draw these interactions of thoughts, feelings, physical sensations and behaviours in a diagram that shows the client how these vicious circles are set up (see Figure 10.1).

2.4.2 Interpersonal mechanisms

Safety behaviours also occur in an interpersonal context. A client with social anxiety may believe that he will be judged negatively by others and that he will appear awkward

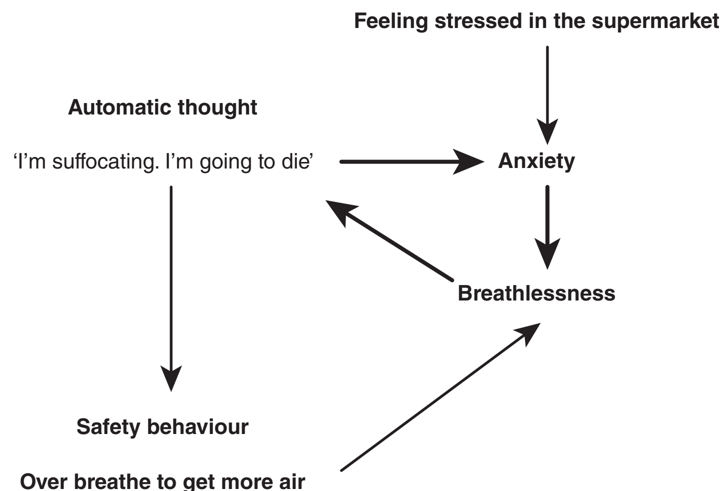

Figure 10.1 Perpetuation of panic disorder

and anxious. It makes sense not to look at them because the expression on their faces is likely to confirm his fears. The client therefore avoids eye contact, which means he encodes in memory his internal impression of the encounter, rather how people are really responding to him. The interpersonal safety behaviour not only prevents him learning what people think of him, but his failure to look at people might actually lead to them thinking he is awkward and odd creating a self-fulfilling prophecy. People with personality disorders often use interpersonal strategies like social avoidance, trying to control others etc. as ways to compensate for negative beliefs about themselves which act like safety behaviours.

2.4.3 Environmental factors

External factors can also help to perpetuate psychological disturbance. From within a CBT framework these can be understood to trap people either through reinforcing their negative beliefs, or restricting their opportunities for behavioural change. Certain maladaptive beliefs can be endorsed by the family as a whole or even society, such as the idea that attractiveness and worth are related to shape and weight. Similarly real-life problems such as unemployment make it difficult for depressed people to believe that there is a future, or to believe that they are of value. The more negative the external environment the more difficult it is to challenge negative thinking. Poverty or illness can reduce the range of activities that someone can engage in and so limit their scope for finding positive reinforcement. Chronic stress or social rejection can contribute to the continuation of anxiety states, and this is often found in post traumatic stress disorder if the client is still in an environment where they are at risk, e.g. a traumatised woman still in contact with her abusive partner.

2.5 Change

The cognitive model assumes that emotional and behavioural change is mediated by changes in beliefs and interpretations. In therapy, this is achieved through systematic testing of these thoughts and beliefs, but the same process occurs naturally when we are exposed to situations that do not fit our assumptions about the world. If information is not consistent with our schema then we either find ways to incorporate the new information into our existing belief system, or we have to change our belief. Positive life events can therefore lift people out of depression. If you think you are unlovable, making a new friend can make you reconsider this. If you think you are a failure, passing an exam improves your sense of competence. Because many of our beliefs are tacit rules, these natural changes often occur gradually and may not be noticed. For instance, someone who has been abused in childhood may not trust anyone, but over time repeated experience of certain people being reliable and honest may lead to revision of this mistrust.

3 PRACTICE

3.1 Goals of therapy

Cognitive therapy has three main goals:

1. to relieve symptoms and to resolve problems;
2. to help the client to acquire coping strategies;
3. to help the client to modify underlying cognitive structures in order to prevent relapse.

Cognitive therapy is problem oriented: whether the complaints are symptoms of psychiatric illness like anxiety and depression, behavioural problems like addiction or bulimia, or interpersonal ones like social anxiety, the primary goal is to help clients solve the problems which they have targeted for change. The whole course of cognitive therapy can be seen as a learning exercise in which the client acquires and practises coping skills, which can be used to deal with the current episode of distress, but also employed if problems recur. The final goal of therapy is the modification of maladaptive schemata. The intention is not to restructure all of a person's irrational beliefs, but only those that are causing problems.

3.2 Selection criteria

3.2.1 Unsuitability criteria

There are no absolute exclusion criteria for cognitive therapy, but if clients are unable to engage in a partnership where they explore and report thoughts and feelings and work on these between sessions they will not be able to sue therapy effectively. This may exclude clients with substance misuse problems who come to therapy intoxicated, clients with severe learning difficulties or dementia etc. Similarly, if the client is unwilling to engage in a structured, problem focused approach and to do homework they should not be taken on.

3.2.2 Suitability for individual therapy

As with other therapies (including drug treatment) severity and chronicity are associated with poor outcome in the treatment of depression. The quality of therapeutic alliance has also been associated with outcome in CBT for depression, but there is some evidence that the alliance builds as a result of the client making some initial improvements as a result of intervention, rather than the alliance acting as the sole vehicle for change. Another factor, which seems to affect outcome is the extent to which the client understands and accepts the cognitive model. For depression particularly, it may be the case that people who can easily engage in problem solving might benefit more form CBT. The implications are that if the clients do not respond to the idea that their thoughts might have some relevance to the problem during the initial sessions then cognitive therapy may not be the right approach.

These factors are usually taken into account when considering clients for cognitive therapy, and a clinician will often test clients' suitability by assessing their acceptance of the cognitive model and their response to cognitive restructuring. Safran and Segal's Suitability for Short Term Cognitive Therapy Scale gives a more systematic method for assessing suitability for short term CBT. (Safran et al., 1993)

Individual or group therapy? Although most cognitive therapists would say that group therapy is less effective than individual therapy, results from controlled trials are contradictory. The advantages of group cognitive therapy in a busy health service are obvious and it can be a very cost-effective approach: group CBT for panic disorder is half the cost of individual CBT. Some services offer group cognitive therapy as the first intervention for all clients, and only those who do not make significant gains are then given individual therapy. In other circumstances clients may be offered a group because there are specific advantages over individual therapy, such as the client being able to see and learn from interacting with others with similar problems. Some clients may initially require individual therapy when they are most distressed but can then go on to a group as their mood improves.

3.3 Qualities of effective therapists

3.3.1 The personal characteristics of effective therapists

First and foremost, cognitive therapists need to have good general interpersonal skills. Although the therapy sometimes appears to place a strong emphasis on cognitive and behavioural techniques these are deemed to be effective only if they are used within the context of a good therapeutic relationship. In CBT for depression, both the quality of the therapeutic alliance and the therapist's competence in using the cognitive behavioural approach contribute to a good outcome (Trepka et al., 2004). Warmth, genuineness and empathy are vital components of this relationship. Cognitive therapists need to have good listening skills, to be able to reflect accurately the cognitive and emotional components of the client's communication, and to demonstrate an active and warm interest in the client. If this is not done there is a real danger that attempts to challenge distorted thinking will be perceived by the client as insensitive or even persecutory. Good therapists seem to be able to get inside the client's cognitive world and empathise while at the same time retaining objectivity.

Many would see the qualities described above as essential to any form of psychotherapy. It is more difficult to specify qualities that make someone a good cognitive therapist rather than a good psychotherapist in general. Perhaps one of the most important factors is the extent to which the therapist can accept the cognitive model. The therapist has to be prepared to work in a problem-oriented way without continually looking for unconscious motives in the client's self-defeating thinking and behaviour. He or she must be able to blend the interpersonal skills described in the last paragraph with a directive approach, which involves a great deal of structure and focus.

3.3.2 The skills shown by effective therapists

Therapists need to be able to identify problems and set goals with clients and structure therapy sessions. They need to be able to use questions skilfully so that the client evaluates their beliefs in a non-threatening relationship. These skills are described in more detail in the section on therapeutic style.

3.4 Therapeutic relationship and style

3.4.1 Therapeutic relationship

The aim of cognitive therapy is to teach the client to monitor thought processes and to reality-test them. Rather than assume that the client's view of the situation is distorted or correct, the cognitive therapist treats every statement about the problem as a hypothesis. Therapy is empirical in the sense that it is continually setting up and testing out hypotheses. Client and therapist collaborate like scientists testing a theory. For instance, a depressed person may believe that there is no point in doing anything because there is no pleasure in life any more.

> *Hypothesis:* If I visit my friend tomorrow I will get no pleasure from it.
>
> *Experiment:* Arrange to visit from 3 p.m. to 4 p.m., and immediately afterwards rate the amount of pleasure I get on a 0-10 scale.

Most depressed people find they get at least some enjoyment out of activities they used to find pleasurable.

Experiments like this can gradually erode the belief that it is not worth doing anything by providing evidence that there is still pleasure open to them and so increase the person's motivation. Teaching the client to be a 'personal scientist' is done through collaboration rather than prescription. Wherever possible the therapist will encourage the client to choose problems, set priorities and think of experiments. This collaboration is the hallmark of cognitive therapy and there are a number of reasons for including the client in the problem-solving process as much as possible.

- Collaboration gives the client a say in the therapy process and so reduces conflict.
- Collaboration fosters a sense of self-efficacy by giving the client an active role.
- Collaboration encourages the learning of self-help techniques, which can be continued when therapy is ended.
- Collaboration allows an active input from the person who knows most about the problem.

Collaboration also serves to reduce the sorts of misinterpretation that can sometimes affect the therapeutic relationship. In non-directive therapies, the impassive stance of the therapist means that the client has to construct an image of the therapist based on her own predictions and rules about people. The resulting misinterpretation (transference) can be used therapeutically. Cognitive therapy wants to reduce this and does not use the relationship as

the focus of therapy. It sees the therapist and client as partners in the process of problem-solving. This does not prevent the therapist being very active and directive at times, but it always gives space for the client to contribute and give feedback on what the therapist is doing. With more severely depressed clients there is often a need for a lot of direction at first, but as the mood improves and the client learns the principles of cognitive therapy the relationship becomes more collaborative. Ideally by the end of therapy the client is doing most of the work and thinking up his or her own strategies for change. When the therapist is most directive at the beginning of treatment he or she must also be most empathic in order to establish rapport.

3.4.2 Therapeutic style

In the collaborative relationship the client and therapist are co-investigators trying to uncover the interpretations and evaluations that might be contributing to the client's problems. This is an inductive process of guided discovery. Wherever possible the therapist asks questions to elicit the idiosyncratic meanings which give rise to the client's distress and to look for the evidence supporting or refuting the client's beliefs. This use of questioning to reveal the self-defeating nature of the client's automatic thoughts has been termed *Socratic questioning*, which is a defining feature of the therapeutic style of cognitive therapy.

Another characteristic feature of cognitive therapy is the way in which the session is structured. At the beginning of each session an agenda is set, with both client and therapist contributing to this. Usually the agenda will include a brief review of the last session, developments in the last week and the results of homework assignments. The work then goes on to the major topic for the session. Anyone listening to a cognitive therapy session will also be struck by two further features: the use of summaries and feedback. Two or three times during a session the client or therapist will summarise what has been going on so far. This helps to keep the client on track, which is particularly important if anxiety or depression impairs concentration. Asking the client to summarise also reveals whether or not the therapist has got a point across clearly. The therapist regularly asks for feedback about his or her behaviour, the effects of cognitive interventions, and so on.

3.5 Assessment and case formulation

3.5.1 Assessment

Unlike many other therapies, cognitive therapy has embraced the diagnostic system in psychiatry, so a good assessment involves ensuring an accurate diagnosis is made. The reason for this is that the basic cognitive model is modified for the particular disorder that is being treated. An illustrative example of this would be anxiety disorders. All anxiety disorders have in common an exaggerated perception of threat and a reduced perception of the person's ability to cope with that threat. But the exact nature of the threat differs between disorders. In panic disorder it is the internal body sensations that are misinterpreted in a catastrophic way;

in health anxiety similar body sensations are misinterpreted as a longer term, less immediate threat. Having a clear understanding of the nature of the disorder helps to orient the assessment, case formulation and treatment plan.

A cognitive therapy assessment, like the therapy itself, is problem focused. If the problem is panic attacks the therapist will ask about the frequency and severity of the panics, situations that might trigger them, the symptoms (cognitive, behavioural, emotional and physical) and the consequences. The client's pressing concerns are identified and explored from a cognitive behavioural perspective, which is the beginning of the case formulation. In panic, the therapist will ask detailed questions about what actually happens during an attack, often focusing on a recent episode as a specific example:

- Where were you when the attack occurred? What were you doing?
- What were the first things you noticed?
- What happened next?
- What were you feeling physically? (looking for symptoms of autonomic nervous system arousal such as palpitations, chest tightness, breathless, sweating, shaking)
- What went through your mind when you started feeling this way? (looking for catastrophic thoughts of death, collapse, fainting, loss of control)
- When the attack was at its worst how strongly did you believe you would die/collapse/lose control?
- Did you do anything at the time to try to keep yourself safe and prevent this from happening? (identifying safety seeking behaviours)
- What effect did these have?
- What happened at the end of the attack?

In assessing problems, the therapist will make use of questionnaires and rating scales to assess the level of depression, anxiety or other problems. There are disorder specific questionnaires for disorders such as obsessive compulsive disorder, post traumatic stress disorder and panic that list common thoughts and behaviours and help the therapist home in on which ones are relevant for the client in front of them. Having got a picture of nature and severity of the problems the therapist will also want to look at the impact of these problems on the client's life. What can't they do because of the problem? What is the effect on their family and friends? In depression the degree of functional impairment, inactivity and withdrawal needs to be assessed; in anxiety the level of avoidance of particular situations. An essential component of the assessment will be the degree of hopelessness the client feels about their problems and the extent to which this might put them at risk of harming themselves. The risk assessment also needs to evaluate any risk to others directly or indirectly through negligence etc. At this stage the therapist often asks about protective factors such as supportive relationships and also the strengths and coping abilities the client can bring to their problems.

The assessment will encompass an understanding of what the clients wants to get out of therapy. This can help to start the process of problem identification and goal setting which will be refined once the therapy begins. It also helps the therapist assess if the goals are achievable and appropriate for this type of therapy. There will be a discussion of the nature of cognitive therapy and the cognitive model with reference to the symptoms and problems

the client has brought. A brief description of the cognitive model is usually given during the assessment together with an explanation that this is a structured, problem focused therapy that is mainly aiming to deal with here and now difficulties; the therapist explains that it is an active, collaborative partnership in which the client plays an active part and will be expected to do self-help assignments between sessions. The response of the client to this will determine whether or not they think they can work in this way. Criteria for selecting clients for CBT have been described already.

It is good practice to take a developmental history during the assessment, but the depth of this will depend upon the type of problem. Straightforward focal problems like phobia and panic may not require a detailed history, apart from enquiries about any specific traumatic incidents that might have triggered the problem. Clients with depression on the other hand usually have childhood experiences that have shaped their negative views of themselves that need to be understood to some degree. People with personality disorder will usually have had significant experiences of unmet childhood need or abuse that needs to be explored to some degree in the assessment.

3.5.2 Case formulation

It may sometimes be possible and reasonable to complete a case formulation at assessment, but the cognitive model emphasises the collaborative and empirical nature of the therapy and so it is only over time that sufficient information is gathered to have a full formulation. Cognitive therapists distinguish the maintenance formulation, which focuses on factors that perpetuate the disturbance from the developmental formulation which focuses on the acquisition of the disturbance. All CBT cases must have a maintenance formulation. This will be guided to some degree by the diagnosis, which provides a road map of the sorts of mechanisms at play for that specific disorder, but this will need to be modified for the individual client. The maintenance formulation is derived from questioning at assessment, data from questionnaires, but more importantly data the client brings back from self-monitoring homework during the early stages of therapy. Monitoring thoughts and behaviours are the best way to gather information that leads to an understanding of how they interact to form what are often vicious circles trapping the person in their emotional disorder. Figure 10.1 presents a diagrammatic summary of the maintenance formulation. This sort of diagram is collaboratively developed with the client and explicitly shared with them.

Some degree of developmental conceptualisation will be done with each client, but as we have seen, the depth of this can vary. It is less likely to be derived from the initial assessment and may take time over the whole course of therapy, because the underlying rules for living will not always be obvious. At its most basic level it will simply describe the history of the problem and any precipitants identified. At the next level it is more of a problem formulation that describes the origins of beliefs specific to the target problem, e.g. a client with panic disorder who has fears of impending madness and losing control, may have had demanding parents and developed an underlying belief that she has to be in control at all times. The fullest level of case conceptualisation includes a detailed account of childhood experience and

how it shaped core beliefs or schemas, together with an understanding of compensatory beliefs and strategies. This fullest level will be needed for clients with personality disorders and some more complex depressive and anxiety disorders.

3.6 Major therapeutic strategies and techniques

3.6.1 Major therapeutic strategies

Early on, strategies are aimed at helping to socialise the client into the cognitive model by identifying how thoughts and feelings are linked, to provide coping strategies for immediate crises and to help the client get some distance from the constant flow of maladaptive thinking. In the next phase of therapy the aim is to help the client identify cognitions and behaviours that might be maintaining their problems and to begin to test the validity and helpfulness of these thoughts and actions. The last phase of therapy involves identifying and challenging underlying maladaptive beliefs and developing a relapse prevention plan.

Conceptualisation: Cognitive therapy is based on a coherent theory of emotional disturbance, and this theory can be used to conceptualise the client's problems. The clearer the conceptualisation, the easier it becomes to develop strategies (i.e. general methods for solving the client's problems) and techniques (specific interventions). For instance, a woman presented with complaints of fatigue and memory problems, but did not have any physical cause for these symptoms. The initial formulation was that the symptoms were stress related, and over the course of two assessment interviews the therapist was able to construct a clearer picture of the problem using the cognitive model. The client had a very poor self-image and was in a difficult marriage where her husband was very critical. She described a constant stream of thoughts criticising herself which occurred whenever she needed to make decisions. She was also able to identify negative thoughts about the marriage ('It's hopeless, I'm trapped`). The cognitive formulation explained her memory problems as a natural result of only partly attending to anything: she was distracted by the running commentary she gave on her actions. Her fatigue probably resulted from the frequent negative thoughts she was having about herself and her marriage.

Because she had a belief that there was nothing she could do about her marital problems she tended to put these thoughts to the back of her mind using 'cognitive avoidance', and selectively focused on the physical symptoms. This in turn led to a further set of negative thoughts – 'Is there something wrong with my brain? Am I going senile?' This formulation allowed the therapist to develop a comprehensive treatment strategy.

Identifying negative automatic thoughts: Early in therapy the therapist teaches the client to observe and record negative automatic thoughts. Initially the concept of an automatic thought is explained: it is a thought or image that comes to mind automatically and seems plausible, but on inspection is often distorted or unrealistic. Thoughts the client has during the session can be used to illustrate this, e.g. in the first session a depressed client may be thinking 'I don't know why I've come, there's nothing anyone can do for me.' Written materials are also

used to explain the basic features of therapy. The client is then given the homework task of collecting and recording negative automatic thoughts. The exact format of this will depend on the problem. A depressed client will be asked to monitor depressed mood, recording the situation that triggered a worsening of depression, and the thoughts associated with it. Someone with an alcohol problem would monitor cravings for drink, and again record the situations in which they occurred and the thoughts that precipitated them. This phase of identifying thoughts help clients to start making the link between an event, their automatic thoughts and the resulting emotion or behaviour. Identifying thoughts may also be therapeutic in its own right, since just recording negative thoughts sometimes reduces their frequency. Clients should try to record their thoughts as soon after the stressful event as possible, when it is fresh in their mind.

Testing negative automatic thoughts: When the client has learned to identify the maladaptive thinking, the next step is to learn how to challenge the negative thoughts. Through Socratic questioning the therapist shows the client how to change his or her thinking. This cognitive restructuring by the therapist usually brings relief in the session, but it takes longer for the client to practise challenging thoughts outside the therapy session, which becomes a situation where the therapist models the process of cognitive restructuring and gives the client feedback on his or her success at the task. Clients are encouraged to use a form to record and challenge their automatic thoughts (see p. 000**[C10Q1]**) to help them internalise the process of identifying and modifying negative automatic thoughts.

There are a number of methods the therapist can use to help a client modify negative thinking:

Reality testing: This is probably the most common method of cognitive restructuring. The client is taught to question the evidence for the automatic thoughts. For example, you hear that your five-year-old son has hit another child at school. You immediately think 'He's a bully. I'm a useless parent, and feel depressed.' But what is the evidence that your son is a bully? Has he done this sort of thing before? Is this unusual behaviour for a five-year-old child? Bullying implies an unprovoked attack. Could he have been provoked? What is the evidence that you are a useless parent? Have you been told by anyone in your family that you are doing a bad job? Is a single instance of bad behaviour in a five-year-old child proof that you are a bad parent?

Looking for alternatives: People who are in emotional crisis, especially if they are depressed, find it difficult to examine the options that are open to them. They get into a blinkered view of their situation. Looking for alternatives is a way of helping them out of this mental set. The therapist gently asks for alternative explanations or solutions and continues until as many as possible are generated. At first these will probably all be negative but after a while the client will start to come up with more constructive alternatives.

Reattribution: A more specialised form of the search for alternatives involves reattributing the cause of, or responsibility for, an event. A client who experiences panic attacks may believe that the physical sensations of dizziness and a pounding heart are signs of an impending heart attack. The therapist, through education, questioning and experimentation, helps the client to reattribute the cause of these experiences to the natural bodily sensations of extreme

anxiety. For example, the client who attributes her son's behaviour to her failure as a mother can be taught to change the focus of responsibility; many factors contribute to a child's behaviour, and a parent does not have control of all of them.

Decatastrophising: This has been termed the 'What if' technique. The client is taught to ask what would be the worst thing that could happen. In many cases when the fear is confronted it becomes clear that it is not so terrible after all. For example, you are preparing to visit a friend for the weekend and do not have much time to pack. You think, 'I can't decide what to pack. I mustn't forget anything.' You get into more and more of a panic trying to remember everything in time. Why would it be so awful if you did forget something? Would it be the end of the world if you turned up without a toothbrush?

Advantages and disadvantages: This is a very helpful technique to enable clients to get things into perspective. If a difficult decision has to be made or if it seems difficult to give up a habitual maladaptive behaviour, the client can list the advantages and disadvantages of a certain course of action.

3.6.2 Major therapeutic techniques

Behavioural techniques in cognitive therapy serve two purposes: they work to change behaviour through a broad range of methods; and they serve as short-term interventions in the service of longer-term cognitive change. This second goal differentiates the behavioural tasks used in cognitive therapy from those used in more conventional behaviour therapy. These tasks are set within a cognitive conceptualisation of the problem and are used to produce cognitive change. Seen in its simplest form, behavioural work changes cognitions by distracting clients from automatic thoughts early in the process of therapy; and challenging maladaptive beliefs through experimentation. Behavioural methods are often used at the beginning of therapy when the client is most distressed and so less able to use cognitive techniques.

Activity scheduling: This is a technique that is particularly useful with depressed clients but can be applied with other problems too. The rationale for scheduling time centres on the proposition that when they are depressed, clients reduce their level of activity and spend more time ruminating on negative thoughts. The schedule is an hour-by-hour plan of what the client will do. As with all the procedures in cognitive therapy, this needs to be explained in some detail and a clear rationale given. It is often set up as an experiment to see if certain activities will improve mood. The therapist stresses that few people accomplish everything they plan, and the aim is not to get all the items done but to find out if planning and structuring time can be helpful. Initially the aim may just be to monitor tasks together with the thoughts and feelings that accompany them. The emphasis is usually on engaging in specific behaviours during a certain period rather than the amount achieved. For instance, a client would be encouraged to decide to do some decorating between 10 a.m. and 11 a.m. on a certain day, rather than plan to decorate a whole room over a weekend. These tasks are set up as homework assignments and the results discussed at the beginning of the next session.

Mastery and pleasure ratings: This technique can be used in conjunction with activity scheduling. Clients rate how much mastery (feelings of success, achievement or control) or pleasure they get out of a task (on a 0–10 scale). Since depressed clients often avoid engaging in pleasant activities, this method allows the therapist to establish which activities might be enjoyable for clients and to encourage them to engage in them with greater frequency. It also challenges all-or-nothing thinking, by showing that there is a continuum of pleasure and mastery rather than experiences that are: (1) totally enjoyable or unenjoyable; and (2) yield complete success or failure.

Graded task assignments: All-or-nothing thinking can also be challenged using graded task assignments. Many clients think, 'I have to be able to do everything I set myself, or I have failed.' The therapist begins by setting small homework tasks which gradually build up m complexity and difficulty The client is encouraged to set goals that can realistically be achieved, so that he or she completes a series of successful assignments.

Behavioural experiments: We have already seen how behavioural experiments are an important component of cognitive therapy. Hypotheses are continually generated and put to the test. This usually involves a negative prediction of some form. For instance, an anxious client may state that he is too anxious even to read. An experiment can be set up in the therapy session where the client reads a short paragraph from a newspaper, thus disproving the absolutism of this statement. The client can then go on to read articles of increasing length over the following week. Experiments are often set as homework. For instance, a depressed client who firmly believes that she is unable to go shopping could be asked to go shopping with her husband. Even if the client is not able to carry out the assignment the experiment is not a failure because it provides valuable information about what might be the blocks to the activity.

(a) Other behavioural techniques Cognitive therapy employs a variety of other behavioural techniques where appropriate. Cognitive and behavioural rehearsal is frequently used during the session in preparation for a difficult homework assignment. Role-play can be a very effective cognitive change technique. When clients have practical problems that need to be solved, behavioural techniques based on a skills training model are especially useful. This will usually involve forms of assertiveness training or social skills training for people who have deficits in interpersonal skills.

(b) Schema change methods All the techniques described so far can be applied to help elicit and change underlying beliefs. In addition some techniques may be specifically applied to change deeply held core beliefs or schemas. *The Historical Review of Schemas* involves testing the evidence for and against the belief across the individual's lifespan. While many clients will find evidence for their belief that they are inadequate or doomed to being abandoned from their recent experience, it is more difficult for them to bias information from early childhood in the same way. *The Continuum Technique* is a method where all or nothing thinking is challenged by plotting it on a continuum and the *Positive Data Log* involves collecting daily instances which discount the client's core beliefs.

(c) Treating clients with personality disorders There is not room in this chapter to describe the treatment of personality disorders in detail (see Beck et al., 1990; Young et al., 2003). The schema change techniques just mentioned play an important role in working with this client group. Because it can be difficult to establish a therapeutic alliance, and because of the strength with which the dysfunctional beliefs are held, treatment is usually longer than with emotional disorders. Clients often find it difficult to identify automatic thoughts and so much of the work has to be done at the schematic level. Repeated recognition of core beliefs and the behavioural strategies stemming from them is often necessary before change can occur, and sometimes a much more confrontational style is needed to overcome schema avoidance (Young et al., 2003). This can include the use of emotive techniques to activate schemas. For instance, a schema may be activated by reconstructing a traumatic scene from childhood in role-play. This is often associated with powerful feelings of fear, hurt and anger. Initially the client is unable to think rationally and is overwhelmed by the feelings, but a skilful therapist can help the client get some distance from the affect without getting caught up in it. Cognitive restructuring can then be used to challenge guilt or blame the person feels for the trauma or abuse, and to challenge beliefs that the past must always poison the present. More active techniques like imagery re-scripting can help to change the sense of powerlessness that is often part of the memory. The conceptualisation is even more important in this work than in standard cognitive therapy. To guide the interventions the therapist needs a clear picture of how core beliefs were developed as a result of childhood experiences, how compensatory beliefs and coping strategies emerged, and how these schemata operate in the clients' present to maintain the maladaptive interpersonal patterns. Sharing this conceptualisation with the client can help give meaning to a seemingly chaotic and meaningless present.

3.7 The change process in therapy

Cognitive therapy aims to effect change by creating situations where old beliefs can be tested and updated through the provision of new information. This can occur through verbal discussion and examination of the evidence for the belief or its logical consistency, or through behavioural experiments that test the beliefs. At the beginning of therapy the emphasis is on conceptualising the client's problems, teaching the cognitive model and producing early symptom relief. Techniques aimed at symptom relief in the early stages of therapy tend to be more behavioural. As therapy progresses the client learns to monitor and challenge automatic thoughts and this forms the major focus in therapy. As the client's problems reach some resolution the emphasis shifts to identifying and challenging underlying assumptions, and to work on relapse prevention. The process of change is not always smooth. The client may come with very different expectations of treatment than the therapist and it may take longer to help them see for themselves that the model and methods can be helpful to them.

4 CASE EXAMPLE

4.1 The client

Cindy was a 33-year-old artist who had been troubled by low mood on and off since her teens. Even when not suffering from depression she had a very poor opinion of herself and doubted her ability to make anything of her life. She berated herself for not having a partner or children, criticised herself for not making more of her career, and considered herself a failure all round. Cindy had problems settling down to mundane tasks or planning her week because she found it hard to concentrate and stick with humdrum chores. It felt like there was one side of her that wanted to live a conventional life, but another side that saw this as boring and ordinary. At weekends she would start drinking with friends in the early evening and then go out clubbing till the early morning. She often found it hard to remember what had happened the night before and feared that she had behaved outrageously. Her inability to restrict her drinking and the effects of her binges further added to her sense of shame and failure.

Cindy described an unhappy childhood. She had never really felt loved and valued and worried that her brother who was two years older was both more able and more appreciated. Her father was a moderately successful artist, but had an erratic, unpredictable character, exacerbated by his heavy drinking. He had left him when Cindy was 11 and her contact with him since then had been fitful. She felt they were similar personalities, so they either got on really well or were at each other's throats. Since she had grown up she believed he saw her artistic efforts as competition: he always wanted to talk about his own work and never seemed to praise her for her work. Her mother was somewhat morose; she was very hard on herself but also hard on her daughter, particularly about her heavy drinking. Cindy's brother was working abroad as an IT consultant. Their relationship had improved now they were adults, but she still couldn't help making comparisons: he seemed to have a successful career and was planning to return to England to live with his partner.

Cindy had found school difficult. She wondered if she had been dyslexic because she had always done better at non-verbal subjects. She did not like the rules and regulations of school, but generally complied and did not get into trouble. She was popular with the others but was never considered cool. After school she went to Art College and then did various part time jobs while continuing her art work. Cindy had had a number of relationships, none lasting more than a year. She tended to go out with men she had met while clubbing. Although they seemed exciting initially, she later usually found them shallow.

4.2 The therapy

4.2.1 Development of the therapeutic relationship

Cindy was eager to take part in therapy and was very motivated. Although she did have some feelings of shame about her behaviour, the compassionate conceptualisation, which

emphasised how she was acting in this way to cope with unpleasant thoughts and feelings, helped her to feel understood and not judged. As she monitored her binge drinking and self-criticism, and then began to find changes in her thoughts and behaviour, the therapeutic alliance strengthened. When at a later stage in therapy the developmental conceptualisation was shared with her, she had sufficient trust in the therapist not to feel overwhelmed by the feelings evoked by this exploration of her underlying beliefs.

4.2.2 Assessment and formulation of the client's problems

The assessment led to an initial maintenance conceptualisation of Cindy's problems. Her self-criticism seemed to pervade her life. She attacked herself for what she didn't do and for what she did do. There was a vicious circle in which her low self-esteem, low confidence and belief that she would never be organised and successful led her to avoid difficult or onerous tasks, but this avoidance simply confirmed her negative beliefs about herself. There was also a vicious circle involving her excessive drinking. Through the week she would either spend her time in a disorganised state escaping from negative thoughts and feelings, or she would throw herself into her art, sometimes working 12 hours a day. By the end of the week she began to feel tense and tired and gave herself permission to relax and unwind: 'You'll feel better if you have a drink. You've worked hard, you deserve to enjoy yourself.' Her binge drinking made her feel unwell for a couple of days, so she was then unable to get her work done and she criticised herself even more. Because she lost her inhibitions when very drunk she often behaved in ways she later regretted, and this further added to her self-disgust. This conceptualisation is shown in Figure 10.1. A developmental conceptualisation was developed over the course of therapy and is described below.

4.2.3 Therapeutic strategies and techniques

The two main aims of therapy were to help Cindy control her binge drinking and to improve her self-esteem. The therapist began by helping her to understand the factors that might be maintaining her low mood and low self-esteem. A cost-benefit analysis of drinking showed that although she enjoyed it, felt relaxed and felt more socially confident, the alcohol tended to make her more depressed and less productive overall. Cindy agreed it might be worth cutting down on her alcohol intake. She kept a record of her drinking and a diary of what she did during the week; she rated the activities for pleasure and mastery.

The activity schedule was used to help her get a balance in her daily routine, between avoidance and overwork. The therapist helped her to explore what she would like to achieve and how she might get there, as well as encouraging her to find activities, which could combat her depressed mood. She felt that avoiding alcohol during the week, exercising and doing her art were all nurturing activities. The therapist also helped her to rehearse in imagination how she could leave a club at a reasonable time instead of staying all night. This involved identifying and challenging some of the permission giving thoughts that encouraged her to

drink more and more. She had variable success with this over the first few weeks of therapy. She began to recognise some of the risk factors and decided that she would be better off meeting friends who only drank small amounts and went home early rather than staying with her old circle. She found that in weeks during which she looked after herself she felt much better and was much more productive. Her difficulty in doing this every week was a good source of automatic thoughts.

The habit of berating herself up for failures was very strong and she would easily think: ‘I’ve done it again. I’m never going to change. I’ve got no self-control.’ She learned to identify these thoughts in the session and outside the session using the Dysfunctional Thought Record. Recording and testing these self-critical thoughts became the main component of the middle phase of therapy. She found that she had negative thoughts about many things that happened on a day-to-day basis as well as things that had happened in the past. She noticed that these seemed to be worse when she was with her mother who was overtly critical of her. Repeatedly using the thought record helped her to feel stronger and not to fall into believing her mother’s criticism. Cindy had in the past been quite interested in Buddhism and meditation; the therapist encouraged her to return to meditating as a means of both nurturing herself and helping to break the vicious cycle of depressive thoughts. She began to recognise her self-critical thoughts as simply thoughts and worked on accepting herself as she was rather than demanding she be different.

By this time Cindy was bingeing less frequently and had more weeks during which she achieved the things she wanted to do. Therapy moved on to exploring the underlying beliefs that made her vulnerable to thinking and feeling so badly about herself. She readily understood that the origins of this had been in her childhood. She had seen her brother apparently succeeding effortlessly while everything seemed difficult for her. Her mother modelled a pessimistic, fatalistic view of the world and criticised her directly, while her father modelled some of the out-of-control behaviour she later fell into herself. She therefore developed the core belief that she was a *useless failure*. This pervaded all she did and thought, and a number of conditional beliefs arose from this ‘bottom line’. These included:

‘If I don’t have a successful career, a long term relationship and children, I’m a failure.’

‘If I try to do something I will fail.’

‘If people know the real me they’ll reject me.’

‘If I try to organise my life I’m bound to fail because I’m incompetent.’

Many of the behaviours we had been working on in therapy seemed to arise as compensatory strategies out of these beliefs:

- Work really hard non-stop, or give up.
- Avoid difficult situations.

- Use alcohol to relax and escape from negative feelings.
- Use alcohol to increase confidence and feel part of the crowd.
- Criticise self in order to do better.

She saw that much of her self criticism was like an internal bully she had inherited from her mother, who punished herself as well as Cindy in an effort do better (see Figure 10.2). The therapist helped her to test some of these beliefs for their accuracy and usefulness, replacing them with alternative more helpful beliefs. She found the self-help book *Overcoming Low Self-Esteem* very useful at this stage and was able to create a new 'bottom line'**:** *'I'm good enough. I can get fulfilment from my work and life for its own sake.'* As therapy came to an end Cindy wrote a blueprint outlining what she needed to do to maintain the gains she had made.

4.2.4 Therapeutic outcome

Cindy attended for 12 weekly sessions and then had two follow-up sessions. At her final follow up she was still having occasional drinking spells but these were much less frequent and she was far less critical of herself if they happened. She felt she was more productive in her work and more constructive in her life in general. She felt that overall she was beginning to believe her new bottom line.

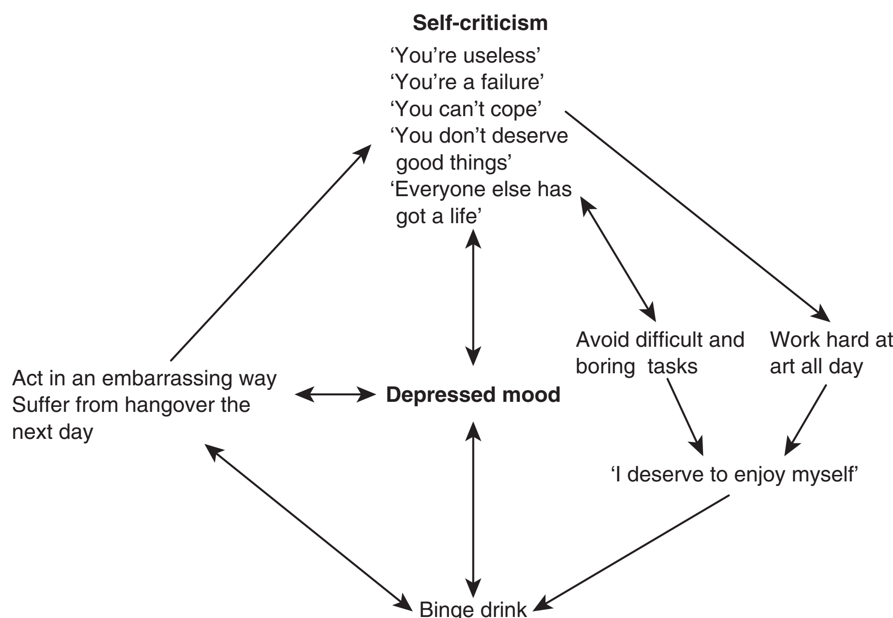

Figure 10.2 Conceptualisation of factors maintaining Cindy's problems

5 OTHER PRACTICE CONSIDERATIONS

5.1 Developments

5.1.1 Brief therapy

Whereas other therapies have often started out as long-term treatments that then developed brief interventions, cognitive therapy as perhaps done in the other direction: treatments for anxiety and depression remain as something between 12 and 20 sessions, but the newer treatments like schema therapy may extend over two or three years. However, there have been briefer CBT interventions developed for use in primary care and in palliative care (Moorey et al., 2009).

5.1.2 Working with diversity

One of the main criticisms of CBT is that it emphasis on rationality may make it difficult for people from non-Western cultures and people with lower educational attainment to engage in the therapy. While it may need to be modified the different cultural groups, there is evidence that this approach can be helpful to people from Asian and other cultures, and there has been work done with people with learning difficulties. CBT is now being applied across the age range from children and adolescents to older adults.

Since its initial application to depression, cognitive therapy has been applied to a wide range of problems. Models and treatments for the subtypes of anxiety disorders have been developed including panic disorder, obsessive-compulsive disorder, hypochondriasis, social phobia and post traumatic stress disorder. Using these conceptualisations as a framework, researchers have developed and tested focused therapies that target the core cognitive and behavioural elements of each disorder. Britain has been in the forefront of the development of cognitive behavioural therapies for psychosis (Fowler, Garety and Kuipers, 1995) and for bipolar affective disorder (Lam et al., 2003), while the adaptation of CBT for people with personality disorders has developed in the USA (Young et al., 2003) and Holland (Arntz and Jacob, 2012). Both sides of the Atlantic have contributed to its application to eating disorders.

The substantial evidence base for CBT has led to its inclusion in the UK's guidelines from the National Institute for Health and Clinical Excellence (NICE: www.nice.org.uk) for the treatment of depression, anxiety, schizophrenia and bulimia: all recommend CBT as one of the core components of management of these conditions. Building on this, the UK government has invested heavily in the training of cognitive behaviour therapists of the treatment of common mental disorders. This initiative, termed Improving Access to Psychological Therapies (IAPT) is delivering evidence-based treatments for anxiety and depression in primary care settings, and evaluating the outcome is using standardised instruments. The services are now broadening their scope so that other evidence-based treatments such as interpersonal therapy are delivered, and there are plans to extend the service to treat long-term conditions and serious mental illness.

Technical developments in CBT have occurred in a number of areas. These have included new techniques for working with imagery, ruminations and worry (Harvey et al., 2004).

There is an increasing emphasis on the use of experiential techniques and behavioural experiments as the most effective way to change cognitions, and less emphasis on verbal cognitive restructuring techniques (Bennet-Levy et al., 2004).

The third wave cognitive therapies such as Dialectical Behaviour Therapy (DBT: Linehan, 2012), Acceptance and Commitment Therapy (ACT: Hayes, 2004), Behavioural Activation (BA: Jacobson et al., 2001) are an exciting new direction for the cognitive behavioural approach. These therapies share a foundation in radical behaviourism and an interest in the *function* of problematic behaviours, thoughts, emotions and physical sensations rather than their *content* (Hayes, 2004). According to Hayes they emphasise 'contextual and experiential change strategies rather than direct and didactic ones'. They approach thoughts very differently from traditional 'second wave' CBT. Instead of being taught to challenge negative thoughts, clients are helped to acknowledge the thoughts without engaging with them. This is done through experiential exercises (ACT) or mindfulness practice (DBT). The behavioural component of therapy may involve a functional analysis of unhelpful behaviours or identifying behaviours that help you work towards your life values (ACT). An important new development in these approaches is the idea of directly experiencing negative emotions without engaging in ruminations or avoidance behaviour. Mindfulness Based Cognitive Therapy (MBCT: Segal et al., 2002) uses this as one of its main components. It helps people learn to accept whatever we are experiencing in the moment without trying to fix or change it.

5.2 Limitations of the approach

Many of the limitations of cognitive therapy are the same as those that apply to any form of psychotherapy. Motivation to change is an important construct that is not always assessable until therapy is under way. The emphasis placed on homework and self-help can be a limitation for some clients. As we have seen, the question of acceptance of the theoretical model, and the ability and willingness to carry out self-help assignments, must be taken into account when considering clients for therapy. The more clearly difficulties can be defined as problems the easier it is to do cognitive therapy. With vague characterological flaws, which manifest themselves as problems in interpersonal relationships, it is sometimes very hard to find a focus. With such clients the form of therapy described here may not be adequate and the longer-term schema approach may be necessary.

5.3 Criticisms of the approach

Many criticisms have been made of CBT since it first appeared. These include the claim that it is too superficial, does not acknowledge emotions, interpersonal factors or developmental origins of the client's problems. Some of these criticisms are based on a misunderstanding of the approach, but others have some substance, and have led to modifications in the therapy. Schema therapy has been developed in response to the difficulty in using straightforward

cognitive techniques with people with personality disorders. Its emphasis on a longer-term process with the use of experiential change techniques and therapeutic relationship make it much more than integrity of therapy. Third-wave therapies have developed in response to findings that some clients become caught up in the debate between negative thoughts and rational responses. They offer a way of escaping from this dilemma.

5.4 Controversies

Therapists from other schools are very critical of the precedents that CBT now has in government funded programmes. This is because it has strongest evidence base, but evidence that it is more effective than other therapies is difficult to find. It is also difficult to demonstrate that cognitive therapy works through changing underlying cognitive structures. This has led some to conclude that all therapies are equal and should therefore be treated equally. However, this criticism breaks down when we focus on specific disorders: there is good evidence that CBT is more effective for phobias, panic disorder, PTSD and OCD than other therapies.

6 RESEARCH

CBT has the strongest evidence base of all the psychological therapies. It lends itself well to the research design of the randomised controlled trial (RCT) because it has specific protocols for different disorders, can be manualised, and has overt targets for change that can be relatively easily measured. It has also been committed to the empirical method from the outset. Beck's cognitive therapy for depression has been shown to be as effective as anti-depressant medication and has a relapse prevention effect equivalent to that of maintenance medication (Beck and Dozois, 2011). Its effectiveness in severe depression is currently under scrutiny since one of the new third wave therapies (behavioural activation) may actually produce superior results (Dimidjian et al., 2006). In anxiety disorders, the specific cognitive models for panic, social phobia, obsessive compulsive disorder and post traumatic stress disorder have all been shown to be effective treatments, and these disorder specific protocols appear to be more effective than general CBT approaches such as stress management. The UK National Institute for Health and Clinical Excellence (NICE) guidelines recommend CBT as the psychological treatment of choice for anxiety and depression (e.g. NICE, 2011) as well as for eating disorders and chronic fatigue syndrome.

Beck's cognitive approach to personality disorders has not been extensively researched, but Young's schema therapy has been found to be superior to transference focused psychotherapy in the treatment of borderline personality disorder (Giesen-Bloo et al., 2006). Some recent trials of CBT for serious mental illness have raised questions about how many clients with these conditions might actually benefit (Scott et al., 2006; Lynch et al., 2010). Evidence for the third-wave therapies is growing: a recent review found that all now had at least two positive randomised controlled trials (Kahl et al., 2012). Their

equivalence or superiority to standard CBT has not yet been investigated. The empirical standing of cognitive behaviour therapy is strong and its commitment to evaluation means that as more effective forms of the therapy are developed it will be able to continue to adapt and change in a truly scientific way.

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