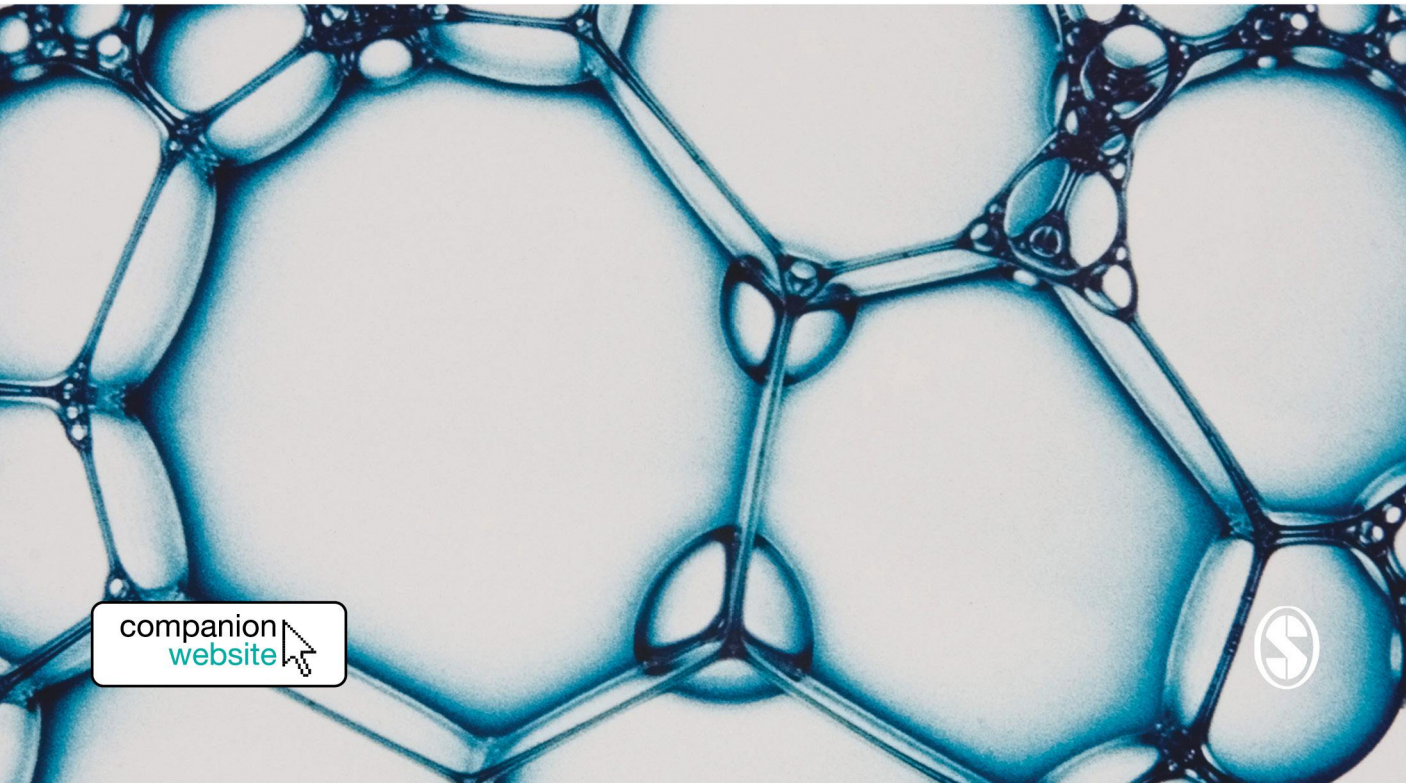
HELEN KENNERLEY,
JOAN KIRK &
DAVID WESTBROOK

EDITION
3

AN INTRODUCTION TO COGNITIVE BEHAVIOUR THERAPY

SKILLS & APPLICATIONS



AN INTRODUCTION TO

COGNITIVE BEHAVIOUR THERAPY

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Dedicated to Joan Kirk (1945–2016)
and David Westbrook (1950–2013)

PRAISE FOR THE BOOK

PRAISE FOR THE THIRD EDITION

'Want to learn to practice CBT with an expert CBT therapist at your side? Then immerse yourself in the third edition of Kennerley et al.'s *An Introduction to Cognitive Behaviour Therapy*, the most complete and up-to-date introductory CBT text available. Each chapter offers clear guidance for management of common clinical dilemmas. Video links demonstrate skills and help therapists really understand CBT as a living, breathing therapy. Even experienced therapists can benefit. This book offers a comprehensive and sophisticated view of CBT in practice.'

Dr Christine A. Padesky, co-founder of the Center for Cognitive Therapy and co-author of *Mind over Mood*

'There are many books that give us the basics of CBT. This one gives us the basics and beyond – what to do, when to do it, how to do it, and why we need to do it. Its mix of case material, techniques and illustrations (including truly enlightening videos of therapy in practice) make the book hard to put down. Whatever the disorder, whatever the age group, whatever the complexity – this book will help you to improve your practise. Consider it mandatory reading for any trainee, supervisor or clinician who takes patient care seriously.'

Professor Glenn Waller, University of Sheffield

'*An Introduction to Cognitive Behaviour Therapy* has been a core text for learners, novice and experienced practitioners, and CBT educators alike since its first edition in 2007. All reputable CBT training programmes have this text on their essential reading lists. The third edition with its comprehensive new features such as the inclusion of videos, new case studies, additional exercises, and a focus on the cultural context of CBT will make what is already a great book indispensable.'

Pamela Myles, University of Reading

'This book is not just an introduction to CBT; it is *the* introduction to CBT. The depth of the authors' expertise as therapists, supervisors and trainers shines through and their knowledge is shared in an accessible way. The new edition includes several contemporary themes and also provides a companion website with video links. Quite simply, new students of CBT should start here.'

Dr Stephen Barton, Newcastle University

'This third edition contains all of the conciseness and clarity of the earlier editions, but with greater depth and scope. Any questions about how to use it in practice can be answered by using the demonstration videos and companion website. Comprehensive, authoritative, practical and friendly, this remains the essential guide to CBT.'

Dave Roberts, Oxford Brookes University

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'This text seeks to genuinely enable therapists' understanding, providing how-to guides, case examples and route maps to learning. The authors' proficient understanding of the breadth and complexity of CBT shines through.'

Professor Willem Kuyken, Mood Disorders Centre

'It is great to see an already outstanding book brought right up to date. As ever, for these authors, excellence begets excellence.'

David Richards, Professor of Mental Health Services Research, University of Exeter

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ABOUT THE AUTHORS

Helen Kennerley is a Consultant Clinical Psychologist working in the NHS and a Senior Associate Tutor with the University of Oxford. Most of her time is dedicated to the Oxford Cognitive Therapy Centre (OCTC), where she is the Director of its Supervision and Training course, and where she carries out CBT training and supervision herself. Her clinical work has been predominantly with survivors of childhood trauma. She has practised CBT for over 30 years, having trained in Oxford and the US. She was a founder member of OCTC and has written several popular cognitive therapy self-help books. In 2002 she was shortlisted for the British Association for Behavioural & Cognitive Psychotherapies (BABCP) award for most influential female cognitive therapist in Britain and in 2015 her book, *Overcoming anxiety: a self-help guide using cognitive and behavioural techniques*, was highly commended in the BMA medical book awards. She is BABCP-accredited as a therapist, supervisor and trainer.

Joan Kirk was a Consultant Clinical Psychologist for over 40 years, having trained in Liverpool, Edinburgh and Oxford. Her original behavioural orientation gradually changed in the 1970s to a cognitive-behavioural position. She was keen to spread the word and so supervised and taught enthusiastically, as well as doing research and writing. She was Head of Adult Clinical Psychology Services in Oxford for many years, and from there she developed the Oxford Cognitive Therapy Centre, and was its first Director. She left the NHS in 2004, to work independently. Joan was a Fellow of the British Psychological Society, and a BABCP-accredited therapist.

David Westbrook was a Consultant Clinical Psychologist, former Director of Oxford Cognitive Therapy Centre and a Senior Associate Tutor with the University of Oxford. Before training as a clinical psychologist he was a psychiatric nurse, eventually becoming the nurse in charge of a specialist behaviour therapy unit in London. This led on to an interest in cognitive therapy, which included training from many of the world's leading CBT therapists. He practised CBT for over 25 years and was involved in training, supervision and research as well as being an NHS clinician, providing a service for clients with severe and complex problems. He was BABCP-accredited as a therapist, supervisor and trainer.

ACKNOWLEDGEMENTS

No text is ever completed without the support, and even sacrifice, of many whose names do not appear on the cover. This is certainly true of *An Introduction to Cognitive Behavioural Therapy*: the generosity of others has been immense and we cannot possibly list everyone by name.

Suffice to say that this book would never have materialised had we not been approached and so very well supported by SAGE and the editorial staff there. It would not have been possible to commit the time to writing it if our family members had not been prepared to tolerate the absences and stresses that we imposed. We would have been unable to conceive of the book had we not already been privileged to learn from wise tutors and colleagues. And this type of text, in particular, can only be written because so many students have given us useful feedback and because so many clients have shared their experiences with us.

So, thank you.

PREFACE

Updating this third edition was a very bitter-sweet task. For years I had worked closely with Joan Kirk and David Westbrook both in the Oxford Department of Clinical Psychology and later in the Oxford Cognitive Therapy Centre (OCTC). Most recently we had collaborated on this introduction to CBT text and had grown used to sharing thoughts, debating ideas and pulling something together that was 'ours'. Sadly, by the time Joan and I began this edition, David had died and by the time I submitted it Joan had passed away after a long illness.

Their deaths have left a significant gap in the CBT world.

Joan was an extraordinary person, a clever, innovative and energetic clinical psychologist who led by wise example and inspired those around her. An early pioneer of CBT, she founded OCTC to promote CBT excellence 25 years ago. In collaboration with the University of Oxford she helped establish one of the UK's earliest CBT Diplomas. She also co-edited one of the best-selling early CBT texts (*Cognitive behavior therapy for psychiatric problems*: Hawton et al., 1989). Joan's professional life is rich with achievements and she was, deservedly, made a Fellow of the British Psychological Society. However, those of us lucky enough to know her will best remember her unstinting generosity, warmth, humour and her love of parties.

David was, in the words of our friend Gillian Butler, 'a big man with a big brain and a big heart.' Like Joan, he was talented and versatile: he was a clinician, manager, researcher and innovator. Like Joan, he was motivated by the desire to offer the very best to both clients and practitioners. He achieved this through his clinical work, his training of others and his research and writing. He co-edited the very successful *Oxford guide to behavioural experiments in cognitive therapy* (Bennett-Levy et al., 2004) and he was writing and publishing right up to his death. He was a Founding Fellow of OCTC and became its Director when Joan retired. Yet despite his many accomplishments and renown, his personal style was always informal. He was ever down to earth and approachable.

As I read and re-read passages in the book I could 'hear' the voices of Joan and David and this was both delightful and sad. Such is the nature of memory that I was transported back to the first edition when we sat around various kitchen tables with various vintages of wine, discussing our ideas, our perspectives and the 'OCTC way'. Some turns of phrase in this text were – and are – undeniably theirs, and I continue to smile at the wry humour of Joan and feel a deep satisfaction in hearing the logical clarity of David. This book is still bursting with their wisdom and sensitivity and I hope you enjoy sharing that.

Helen Kennerley, Oxford, 2016

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VIDEOS

Over **40 videos** are provided online and are referred to throughout your book. Just look out for the video icons in the margins and then visit the website to watch.

Showing how CBT skills and techniques can be applied to common mental health problems, and how key theories and concepts translate into real-life practice, the videos cover a wide range of skills including:

- Eliciting feedback from your client
- Dealing with signs of problems in the therapeutic relationship
- Measuring CBT's effectiveness
- Developing positive imagery
- Setting an agenda

Take a look at the following pages for the full list of videos.

DEVISING A SPONTANEOUS BEHAVIOURAL EXPERIMENT

INTRODUCING THOUGHT DIARIES

CONSTRUCTING A SIMPLE FORMULATION

A man with health anxiety believed that if he became short of breath, he could pass out and die; he therefore made sure that he always stayed within reach of a doctor's surgery. During therapy in the clinic, he had questioned this belief and had begun to develop two new possibilities: that he would not pass out if he became breathless and that it was okay to move beyond the reach of a doctor's surgery. With his agreement, the therapist then drove him into the countryside where neither of them knew the whereabouts of doctors' surgeries. They then ran up and down the road so that he became breathless (an activity he had been avoiding). This meant that he could test out his new belief that he would not pass out, whilst dropping the safety-seeking behaviour of being near a doctor's surgery.

Case Studies and Examples are highlighted in blue throughout the book. Read these to get a sense of how real-life therapy works and to better understand practice.

LEARNING EXERCISES

These learning exercises are available to download from the companion website.

REVIEW AND REFLECTION:

- **Consider what you think about the basic principles of CBT outlined in this chapter. Do they make sense to you? Are there any principles that do not fit, or do not make sense to you?**
- **What do you think of the cognitive theory underpinning CBT? Does it make sense to you? Does it fit with your clinical experience?**
- **Does it matter that the evidence for the theory of CBT is less solid than the evidence for its efficacy as a treatment?**

TAKING IT FORWARD:

- **Observe your own experience of ATs, UAs and core beliefs. Try to tune in to your thoughts and images, especially when you are upset or emotionally aroused in some way. Do your thoughts follow any of the patterns described here? What are the similarities or differences between your experience and our descriptions of different kinds of cognition?**
- **Does this observation of your own thoughts have any implications for your clinical practice?**
- **If so, how will you adapt your clinical practice?**
- **If you are drawn to this way of working, how could you start to take that forward? Are there training and supervision opportunities that you could tap into?**

Learning Exercises can be found both at the end of each chapter and online and are marked by the mouse icon. Complete these to review and reflect on what you have just read.

FURTHER READING

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

The classic text, which should be at the top of your reading list – it gives the original description of CBT, setting out characteristics of the approach.

Westbrook, D., Mueller, M., Kennerley, H., & McManus, F. (2010). Common problems in therapy. In M. Mueller, H. Kennerley, F. McManus, & D. Westbrook (Eds.), *Oxford guide to surviving as a CBT therapist.* Oxford: Oxford University Press.

An interesting chapter where the authors discuss common problems in therapy associated with many of the distinctive features of CBT.

Further Reading suggestions are included in each chapter and are signposted by the bookmark icon. Use these to help you deepen your knowledge and reinforce your learning of key topics.

Date and time	Emotion(s)	Thoughts
	What emotion(s) did you feel? Also rate the strength of the feelings from 0 (none at all) to 10 (the strongest possible)	What went through your mind? Also rate how much you believed the thoughts at the time you had them, from 0 (did not believe at all) to 10 (absolutely sure they were true)

Figure 8.1 Example of a daily thought record

This figure is available to download from the companion website.

Reproducible figures are available to download from the companion website:

- an example daily thought record (Figure 8.1)
- a behavioural experiment record sheet (Figure 9.2) and
- a weekly activity schedule (WAS) (Figure 12.2)

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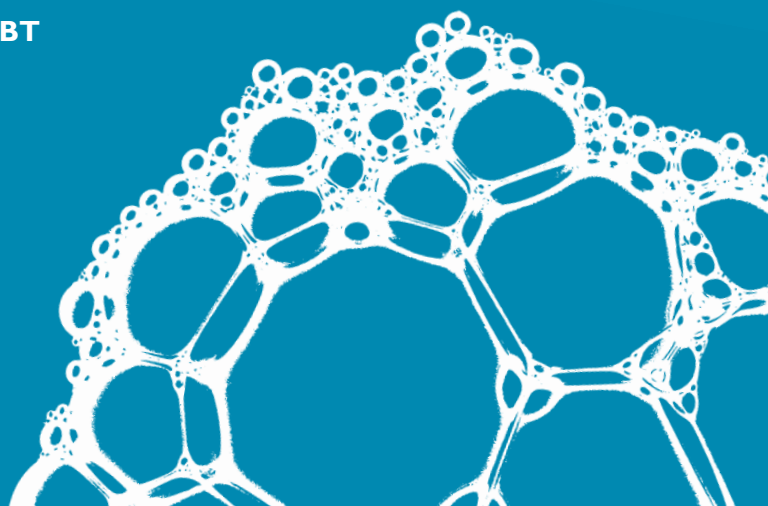
1

BASIC THEORY, DEVELOPMENT AND CURRENT STATUS OF CBT

- **Introduction**
- **A brief history of CBT**
- **Some basic principles**
- **'Levels' of cognition**
- **Automatic thoughts (ATs)/Negative automatic thoughts (NATs)**
- **Core beliefs**
- **Underlying assumptions**
- **Characteristic cognitions in different problems**
- **Generic CBT model of problem development**
- **The current status of CBT**
- **CBT competences**
- **The empirical evidence about CBT**
- **Summary**
- **Learning exercises**
- **Further reading**



INTRODUCTION

In this chapter we will introduce you to the fundamentals of cognitive behaviour therapy (CBT), including the basic theory and the development of the approach. We start here because CBT is sometimes criticised for being a rather simple-minded 'cookbook' approach to therapy: if the client has *this* problem then use *that* technique. However, the approach taken in this book is based not on the mechanical application of techniques but on *understanding*: understanding your client, understanding CBT theory, and bringing the two together in a formulation (see Chapter 4). You should already have some ideas about understanding people, based on your clinical and personal experience. This chapter will start you on the road to understanding CBT theory: CBT 'first principles' if you like.

One further clarification. Talking about CBT as if it were a single therapy is misleading. Modern CBT is not a monolithic structure, but a broad movement that is still developing, and full of controversies. The approach we take in this book is based on the 'Beckian' model, first formulated by A.T. Beck in the 1960s and 1970s (Beck, 1963, 1964; Beck, Rush, Shaw & Emery, 1979). This model has been dominant in the UK for well over 30 years, and we would therefore see ourselves as being in the mainstream of CBT in this country. However, other CBT theorists and clinicians might differ, in major or minor ways, with some of the approaches expounded here. We should also say that although we think that some of the later developments in CBT, such as the 'Third Wave' therapies (Hayes, 2004), are exciting developments that have the potential to enrich CBT greatly, our aim here is primarily to provide a foundation for 'basic' CBT. We therefore restrict our consideration of those developments to a separate chapter (Chapter 17).

A BRIEF HISTORY OF CBT

Just as some knowledge of a person's background can be helpful in understanding his current state, an appreciation of how CBT developed can help us to understand its modern form. Modern CBT has two main influences: first, behaviour therapy as developed by Wolpe and others in the 1950s and 1960s (Wolpe, 1958); and second, the cognitive therapy approach developed by A.T. Beck, beginning in the 1960s but becoming far more influential with the 'cognitive revolution' of the 1970s.

Behaviour therapy (BT) arose as a reaction against the Freudian psychodynamic paradigm that had dominated psychotherapy from the nineteenth century onwards. In the 1950s, Freudian psychoanalysis was questioned by scientific psychology because of the lack of empirical evidence to support either its theory or its effectiveness (Eysenck, 1952). BT was strongly influenced by the behaviourist movement in academic psychology, which took the view that what went on inside a person's mind was not directly observable and therefore not amenable to scientific study. Instead behaviourists looked for reproducible associations between observable events, particularly between *stimuli* (features or events in

the environment) and *responses* (observable and measurable reactions from the people or animals being studied). Learning theory, a major model in psychology at that time, looked for general principles to explain how organisms learn new associations between stimuli and responses.

In this spirit, BT avoided speculations about unconscious processes, hidden motivations and unobservable structures of the mind, and instead used the principles of learning theory to modify unwanted behaviour and emotional reactions. For instance, instead of trying to probe the unconscious roots of an animal phobia, as Freud famously did with 'Little Hans' (a boy who had a fear of horses: Freud, 1909), behaviour therapists constructed procedures, based on learning theory, which they believed would help people learn new ways of responding. The BT view was that someone like Little Hans had learned an association between the stimulus of a horse and a fear response, and the task of therapy was therefore to establish a new, non-fearful, response to that stimulus. The resulting treatment for anxiety disorders, known as *systematic desensitisation*, asked clients to repeatedly imagine the feared stimulus whilst practising relaxation, so that the fearful response would be replaced by a relaxed response. Later developments often replaced *imaginal* exposure (e.g. thinking about a mental picture of the horse) with *in vivo* exposure (approaching a real horse).

BT rapidly became successful, especially with anxiety disorders such as phobias and obsessive-compulsive disorder (OCD), for two main reasons. First, in keeping with its roots in scientific psychology, BT had always taken an empirical approach, which soon allowed it to provide solid evidence that it was effective in relieving anxiety problems. Second, BT was a far more economical treatment than traditional psychotherapy, typically taking 6–12 sessions.

Despite this early success, there were limitations of a purely behavioural approach. Mental processes such as thoughts, beliefs, interpretations, imagery and so on, are such an obvious part of life (and problems) that it began to seem absurd for psychology not to deal with them. During the 1970s this dissatisfaction developed into what became known as the 'cognitive revolution', wherein ways were sought to bring cognitive phenomena into psychology and therapy whilst still trying to maintain an empirical approach that would avoid ungrounded speculation.

Beck had trained as a psychiatrist and as a psychodynamic psychotherapist, but he increasingly felt that there was more that he could offer the clients who did not respond to a psychodynamic intervention. During the 1950s and early 1960s, he and others had already begun to develop ideas about cognitive therapy (CT) and considered the fusion of insight with BT, but their ideas became increasingly influential from the 1970s onwards. The publication of Beck's book on CT for depression (Beck et al., 1979), and research trials showing that CT was as effective a treatment for depression as antidepressant medication (e.g. Rush, Beck, Kovacs & Hollon, 1977), fuelled the revolution. Over the succeeding years, BT and CT grew together and influenced each other to such an extent that the resulting amalgam is now most commonly known as 'cognitive behaviour therapy' – CBT.

SOME BASIC PRINCIPLES

So, what elements of BT and CT have emerged to form the foundation of modern CBT? Here we set out what we see as the most basic principles and beliefs on which our model of CBT is based, so that you can decide for yourself whether you think they make sense – or at least enough sense to be worth giving CBT a try. Below are what we consider to be the fundamental beliefs about people, problems and therapy that are central to CBT. We are not suggesting that these beliefs are necessarily unique to CBT – many of them may be shared by other approaches – but the combination of these principles goes some way towards characterising CBT.

THE COGNITIVE PRINCIPLE

The core idea of any therapy calling itself 'cognitive' is that people's emotional reactions and behaviour are strongly influenced by *cognitions* (in other words, their thoughts, mental images, beliefs and interpretations about themselves or the situations in which they find themselves – fundamentally the *meaning* they give to the events of their lives). What does this mean?

It may be easiest to start from a 'non-cognitive' perspective. In ordinary life, if we ask people what has made them sad (or happy, or angry, or whatever), they often give us accounts of *events* or *situations*: for example, 'I am fed up because I have just had a row with my girlfriend'. However, it can't be quite that simple. If an event automatically gave rise to an emotion in such a straightforward way, then it would follow that the same event would have to result in the same emotion for anyone who experienced that event. What we actually see is that to a greater or lesser degree, people react *differently* to similar events. Even events as obviously terrible as suffering a bereavement, or being diagnosed with a terminal illness, do not produce the same emotional state in everyone: some may be completely crushed, whilst others cope reasonably well. So it is not just the event that determines emotion: there must be something else. CBT says that the 'something else' is cognition: that is, the interpretations people make of the event. When two people react differently to an event it is because they are seeing it differently, and when one person reacts in what seems to be an unusual way, it is because he has unusual thoughts or beliefs about the event: it has an idiosyncratic *meaning* for him. Figure 1.1 illustrates this.

Let's look at a simple example of this process. Suppose you are walking down the street and you see someone you know coming the other way, but she does not seem to notice you.

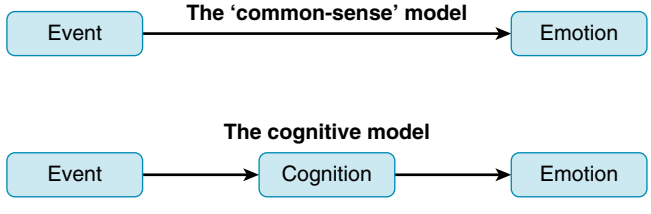


Figure 1.1 The basic cognitive principle

Here are a number of possible thoughts about this event – note how the possible emotional responses arising from those interpretations vary:

- 'I can't think of anything to say to her, she'll think I'm really boring and stupid.' (Leading to anxiety)
- 'Nobody would ever want to talk to me anyway, no one seems to like me.' (Causing depression)
- 'She's got a nerve being so snooty, I've not done anything wrong.' (Triggering anger)
- 'She's probably still hung over from that party last night!' (Resulting in amusement)

This illustrates the fundamental cognitive principle, that different cognitions give rise to different emotions. It also shows the association between certain kinds of cognition and corresponding emotional states: for instance, that thoughts about others being unfair, or breaking rules that we hold dear, are likely to be associated with anger. We will return to this idea later.

There is, of course, nothing new about the notion that meaning is important. The ancient Greek Stoic philosopher Epictetus said over 1,800 years ago that 'Men are disturbed, not by things, but by the principles and notions which they form concerning things.' Yet as we shall see in the rest of this book, the ramifications and elaborations of this simple idea have led to the development of a powerful approach to helping people in distress. By helping people to review their cognitions, we may be able to help them change the way they feel.

THE BEHAVIOURAL PRINCIPLE

Part of the inheritance from BT is that CBT considers behaviour (what we *do*) as crucial in maintaining – or in changing – psychological states. Consider the above example again. If you had either the first or second cognition, then your subsequent behaviour might have a significant effect on whether your feelings of anxiety or depression persisted. If you approached your acquaintance and chatted, you might discover that she was actually friendly towards you. As a result, you might be less inclined to think negatively in future. On the other hand, if you pretended not to see her, you would not have a chance to find out if your thoughts were inaccurate, and negative thoughts and associated emotions might persist. Thus, CBT believes that behaviour can have a strong impact on thought and emotion, and, in particular, that changing what you do is often a powerful way of changing thoughts and emotions.

THE CONTINUUM PRINCIPLE

In contrast to some more traditional medical approaches, CBT believes that it is usually helpful to see mental health problems as arising from exaggerated or extreme versions of normal processes, rather than as pathological states that are qualitatively different

from, and inexplicable by, normal states and processes. In other words, psychological problems are at one end of a continuum, not in a different dimension altogether. Related to this belief are the further ideas that (a) psychological problems can happen to anyone, rather than being some freakish oddity; and (b) that CBT theory applies to therapists as much as to clients.

THE HERE-AND-NOW PRINCIPLE

Traditional psychodynamic therapy took the view that looking at the symptoms of a problem (e.g. the anxiety of a person with a phobia) was superficial, and that successful treatment must uncover the developmental processes, hidden motivations and unconscious conflicts that were supposed to lie at the root of a problem. BT took the view that the main target of treatment was the symptoms themselves and that one could tackle the anxiety (or whatever) directly, by looking at what processes currently maintained it and then changing those processes. Psychoanalysis argued that treating symptoms rather than the supposed 'root causes' would result in *symptom substitution*: that is, the unresolved unconscious conflict would result in the client's developing new symptoms. In fact, a wealth of research in BT showed that such an outcome, although possible, was rare: more commonly, tackling symptoms directly actually resulted in more global improvement.

Modern CBT has inherited BT's approach. The main focus of therapy, at least most of the time, is on what is happening in the present, and our main concerns are the processes currently maintaining the problem, rather than the processes that might have led to its development many years ago. Having said that, CBT does not dismiss the past, far from it, and Chapter 4 on assessment and formulation discusses this further.

THE INTERACTING SYSTEMS PRINCIPLE

This is the view that problems should be thought of as interactions between various 'systems' within the person and in their environment, and it is another legacy from BT (Lang, 1968). Modern CBT commonly identifies four such 'internal' systems:

- cognition;
- affect, or emotion;
- behaviour;
- physiology.

These systems interact with each other in complex feedback processes and also interact with the environment – where 'environment' is to be understood in the widest possible sense, including not just the obvious physical environment but also the social, family, cultural and economic environment. Figure 1.2, based on Padesky and Mooney's five-system framework (Padesky & Mooney, 1990), illustrates these interactions.

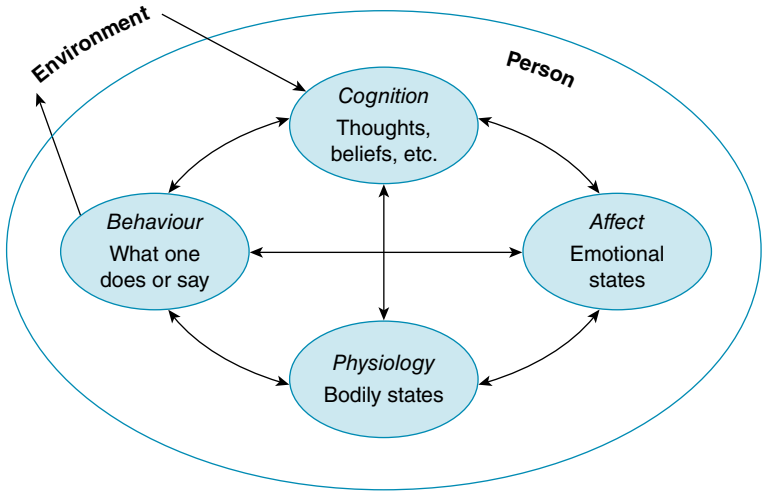


Figure 1.2 Interacting systems

This kind of analysis helps us to describe problems in more detail, to target specific and dynamic aspects of a problem and to gain a richer understanding of its maintenance. We can also consider times when one or more systems are not correlated with the others. For example, 'courage' could be said to describe a state where a person's behaviour is not correlated with emotional state: although a woman is feeling fearful, her behaviour is not overtly fearful. Clinically it can be crucial to identify mis-matches between clients' thoughts, feelings and actions so that we can better understand a person's strengths, needs and perceptions.

THE EMPIRICAL PRINCIPLE

CBT believes we should evaluate theories and treatments as rigorously as possible, using scientific evidence rather than just clinical anecdote. This is important for several reasons:

- Scientifically, so that our treatments can be founded on sound, well-established theories. One of the characteristic features of CBT is that, in contrast to some schools of therapy that have remained little changed since they were first devised, it has developed and made steady advances into new areas through the use of scientific research.
- Ethically, so that we can have confidence in telling people who are receiving and/or purchasing our treatments that they are likely to be effective.
- Economically, so that we can make sure that limited mental health resources are used in the way that will bring most benefit.

THE INTERPERSONAL PRINCIPLE

As Beck's early psychodynamic training taught him, CBT takes place in the context of a dynamic relationship. In CBT this is a *working alliance* as CBT is not 'administered' or 'done to' a client. Instead, we foster a milieu that enables us to work with a person, who engages with full knowledge and consent. This is such an important principle that we have dedicated Chapter 3 to its exploration.

Contrary to what some might expect, we hypothesise about intention and unspoken feelings and we monitor our own cognitive and emotional reactions to clients. Sometimes there is much to be learnt from this and we formulate its impact on our therapy. For example, we might hypothesise that a fleeting look of discomfort during a session is significant and usefully explored because it might reveal a client's relevant but shameful secret, one which serves to maintain the problem. On the other hand it might simply reveal a bout of cramp – so we should always be prepared for our hypotheses to be refuted!

SUMMARY OF CBT PRINCIPLES

These then are what we would take as the basic principles at the heart of CBT. To summarise:

- *The cognitive principle*: it is interpretations of events, not events themselves, that are crucial.
- *The behavioural principle*: what we do has a powerful influence on our thoughts and emotions.
- *The continuum principle*: mental health problems are best conceptualised as exaggerations of normal processes.
- *The here-and-now principle*: it is usually more fruitful to focus on current processes rather than the past.
- *The interacting systems principle*: it is helpful to look at problems as interactions between thoughts, emotions, behaviour and physiology and the environment in which the person operates.
- *The empirical principle*: it is important to evaluate both our theories and our therapy empirically.
- *The interpersonal principle*: we work with an informed and active person and we consider and formulate dynamic aspects of our relationship.

Let us now turn to an elaboration of the fundamental cognitive principles.

'LEVELS' OF COGNITION

So far we have talked about 'cognition' as if it were a single concept. In fact, CBT usually distinguishes between different kinds or 'levels' of cognition. The following account of

levels of cognition is based on what has been found clinically useful; a later section will briefly consider the scientific evidence for some of these ideas.

When we talk of cognitions, we refer not only to thoughts – which can readily be put into words – but to images, too. This convention is rather confused by CBT therapists' widespread use of terms such as 'automatic thoughts' (ATs) and 'negative automatic thoughts' (NATs) as we seem to be excluding images. Be assured that images are relevant cognitions just as thoughts are.

It is worth noting that different CBT practitioners might categorise cognitions differently, and although the following classification is commonly used, it is not the only one.

AUTOMATIC THOUGHTS (ATs)/ NEGATIVE AUTOMATIC THOUGHTS (NATs)

Automatic thoughts (ATs) is a term used to describe a stream of thoughts that almost all of us can notice if we try to pay attention to them. They can be positive, neutral or negative in content. Negative automatic thoughts (NATs), as first described by Beck in his work with depressed clients, are often fundamental to CBT. These are negatively tinged appraisals or interpretations – *meanings* we take from what happens around us or within us. Any of us might experience them.

Think of a recent time when you became upset: anxious, annoyed, fed up or whatever. Put yourself back in that situation and remember what was going through your mind. Most people can fairly easily pick out NATs. For example, if you were anxious, you might have had thoughts about the threat of something bad happening to you ('Oh no – now I'm messing up …') or people you care about ('He's not going to manage this alone …'); if you were annoyed, you might have had thoughts about others being unfair, or not following rules you consider important ('Come on – that's so out of order!'); if you were fed up, there might have been thoughts about loss or defeat, or negative views of yourself ('Here I go again – there's just no point …').

ATs (and therefore NATs) are thought to exert a direct influence over mood from moment to moment, and they are thus of central importance to any CBT therapy. They have several common characteristics:

- As the name suggests, one does not have to *try* to think ATs – they just happen, automatically and without effort (although it may take effort to pay attention to them and notice them).
- They are specific thoughts about specific events or situations. Although they may become stereotyped, particularly in chronic problems, they may also vary a great deal from time to time and situation to situation.
- They are, or can easily become, conscious. Most people are either aware of this kind of thought, or can soon learn to be aware of them with some practice in monitoring them.

- They may be so brief and frequent, and so habitual, that they are not 'heard'. They are so much a part of our ordinary mental environment that unless we focus on them we may not notice them, any more than we notice breathing most of the time.
- They are often plausible and taken as obviously true, especially when emotions are strong. Most of the time we do not question them: if I think 'I am useless' when I am feeling fed up about something's having gone wrong, it seems a simple statement of the truth. One of the crucial steps in therapy is to help clients stop accepting their ATs in this way, so that they can step back and consider their accuracy. As a common CBT motto has it, 'Thoughts are opinions not facts' – and like all opinions, they may or may not be accurate.
- Although we usually talk about ATs as if they were verbal constructs (e.g. 'I'm making a mess of this'), it is important to be aware that they may also take the form of images. For example, in social phobia, rather than thinking in words, 'Other people think I'm peculiar', a person may get a mental image of himself looking red-faced, sweaty and incoherent.
- Because of their immediate effect on emotional states, and their accessibility, ATs are usually tackled early on in therapy.

CORE BELIEFS

At the other end of the scale from ATs, core beliefs represent a person's 'bottom line' (a term coined by Fennell, 1997), their fundamental beliefs about themselves, others, the world in general or the future. Characteristics of core beliefs are:

- Most of the time they are not immediately accessible to consciousness. They may have to be inferred by observation of characteristic thoughts and behaviours in many different situations.
- They manifest as general and absolute statements (e.g. 'I am bad' or 'Others are not to be trusted'). Unlike ATs, they do not typically vary much across times or situations but are seen by the person as fundamental truths that apply in all situations.
- They are usually learned early on in life as a result of childhood experiences, but they may sometimes develop or change later in life (e.g. as a result of adult trauma).
- They are generally not tackled directly in short-term therapy for focal problems such as anxiety disorders or major depression (although they may change anyway). Tackling them directly may be more important in therapy for chronic problems like personality disorders (see Chapter 17).

UNDERLYING ASSUMPTIONS

Underlying assumptions (UAs) can be considered as bridging the gap between core beliefs and ATs. They develop as a response to the core belief and are often referred to as dysfunctional assumptions (DAs) when they backfire and hinder rather than help a person.

Core beliefs give us our fundamental (and often thematic) perspectives whilst UAs can be thought of as 'rules for living', more specific in their applicability than core beliefs but more general than ATs. They often take the form of conditional 'If … then …' propositions, or are framed as 'should' or 'must' statements. They often represent attempts to live with negative core beliefs. For example, if I believe that I am fundamentally unlovable, I may develop the assumptions that

- 'If I always try to please other people then they will tolerate me, but if I stand up for my own needs I will be rebuffed,' or
- 'If I keep a low profile, no-one will see the real me and never know that I am unlovable,' or
- 'I must always put other's needs first, otherwise they will reject me.'

Such UAs offer hope that I can contain the situation and provide a guide to how to live my life so as to overcome some of the effects of the core belief, but it is always a fragile truce: if I fail to please someone, then I am in trouble. When one of my UAs is violated, then NATs and strong emotions are likely to be triggered. Characteristics of UAs are:

- Like core beliefs, they are not as obvious as ATs and may not be easily verbalised. They often have to be inferred from actions or from patterns of common ATs.
- They are usually conditional statements, taking the form of 'If … then …', or 'should/must … otherwise …' statements.
- Some may be culturally reinforced: for example, beliefs about putting others first, or the importance of success, may be approved of in some cultures.
- They become 'dysfunctional' when they are too rigid and over-generalised, not flexible enough to cope with the inevitable complications and setbacks of life.
- They are usually tackled later on in therapy, after the client has developed some ability to work with ATs. It is thought that modifying UAs may be helpful in making clients more resistant to future relapse (Beck et al., 1979).

Figure 1.3 illustrates these levels of cognitions for one kind of belief and also shows some of the dimensions along which the levels vary.

It is easy to assume that core beliefs are 'at the root' of the problem, or are the 'underlying' cause, and that therefore they must be tackled directly for therapy to be effective. Although

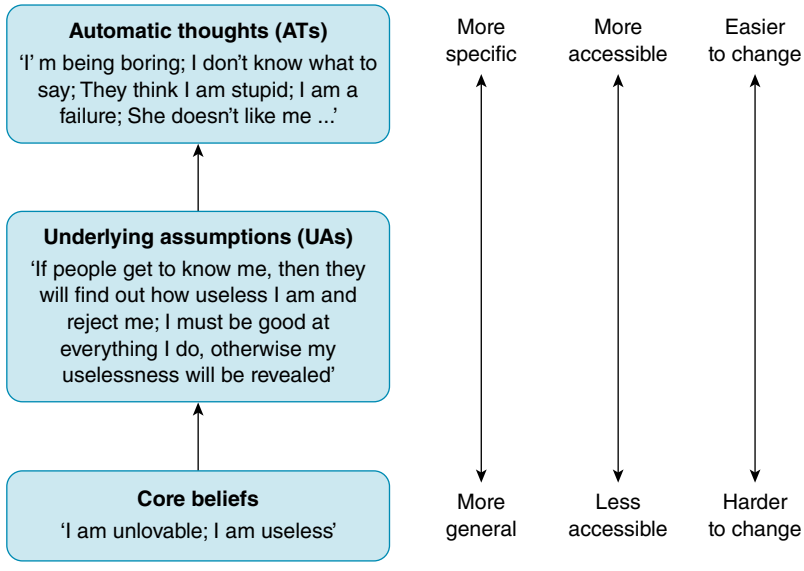


Figure 1.3 Illustration of levels of cognition

this can be the case, we would question this blanket assumption. Core beliefs are certainly more *general* than ATs, but that does not necessarily mean that they are more important. Most successful CBT research to date targets ATs, but that does not make the therapy ineffective or short-lived. This is probably for two reasons:

- People with common mental health problems such as anxiety or depression have a *range* of core beliefs, not just negative and unhelpful ones. Through the process of therapy they can bring their more positive or functional beliefs back into operation.
- Reviewing and building evidence that tests ATs can have an impact, a 'knock-on effect', on core beliefs so we don't need to target core beliefs directly.

Although there is not yet much research evidence, working with core beliefs may be more important in lifelong problems such as very chronic difficulties and personality disorders, where clients may never have formed much in the way of longer-term functional beliefs. So often a child or young person evolves a 'rule for living' that helps them at the time. For example, 'If I please everyone and keep out of trouble no-one will hurt me' would be protective for a bullied and abused child but would hold back the adult. In adulthood it would have lost its usefulness and become dysfunctional, it would need to be reviewed and revised, and because of its long-standing and unchallenged status a therapist might well need to focus on it.

CHARACTERISTIC COGNITIONS IN DIFFERENT PROBLEMS

We mentioned earlier that modern CBT theories see characteristic forms of cognition associated with particular kinds of problem. These characteristic patterns involve both the *content* of cognitions and the *process* of cognition. If we take depression as an example, then the thoughts of depressed people are likely to contain characteristic *contents* (e.g. negative thoughts about themselves or others). Depressed people are also likely to show characteristic general biases in the *way* that they think (e.g. towards perceiving and remembering negative events more than positive ones; or tending to see anything that goes wrong as being their fault; or over-generalising from one small negative event to a broad negative conclusion). Here, we briefly consider some examples. (See also later chapters on specific problems.)

DEPRESSION

As first described by Beck, the characteristic cognitions in depression form the *negative cognitive triad*, namely negatively biased views of *oneself*, of the *world in general* and of the *future*. In other words, the typical depressed view is that I am bad (useless, unlovable, incompetent, worthless, a failure, etc.); the world is bad (people are not nice to me, nothing good happens, life is just a series of trials); and the future is also bad (not only am I and the world bad, but it will always be like this and nothing I can do will make any difference).

ANXIETY

The general cognitive process here is a bias towards *the over-estimation of threat*, (i.e. perceiving a high risk of some unwanted outcome) and/or the *underestimation of ability to cope* (i.e. perceiving oneself as lacking necessary skills). The exact nature of the threat, and therefore the content of cognitions, is different in different disorders. For example:

- In *panic*, there is catastrophic misinterpretation of harmless anxiety symptoms as indicating some imminent disaster (e.g. dying or 'going mad').
- In *health anxiety*, there is a similar misinterpretation of harmless symptoms as indicating illness, but on a longer time scale (e.g. I might have a disease that will kill me sometime in the future).
- In *social anxiety*, thoughts are about being negatively evaluated by others (e.g. 'They will think I am stupid/boring/peculiar').
- In *OCD*, thoughts are about being responsible for, and/or needing to prevent, some harm to oneself or others.

ANGER

In anger, the thoughts are usually about others' behaviour being *unfair*, breaking some implicit or explicit rule, or having hostile intent: 'They ought not to do that, it's not fair, they're trying to put me down.' Just as we saw with anxiety, rapid and extreme conclusions are drawn, thus illustrating the cognitive process and content that leads to anger. In both anxiety and anger this is fuelled by adrenaline, reminding us of the interacting systems of psychological experiences.

GENERIC CBT MODEL OF PROBLEM DEVELOPMENT

Now we can put together the ideas introduced so far to develop a broad picture of how CBT sees the development of problems (see Figure 1.4). This generic model proposes that through experience (most commonly childhood experience, but sometimes later experience), we

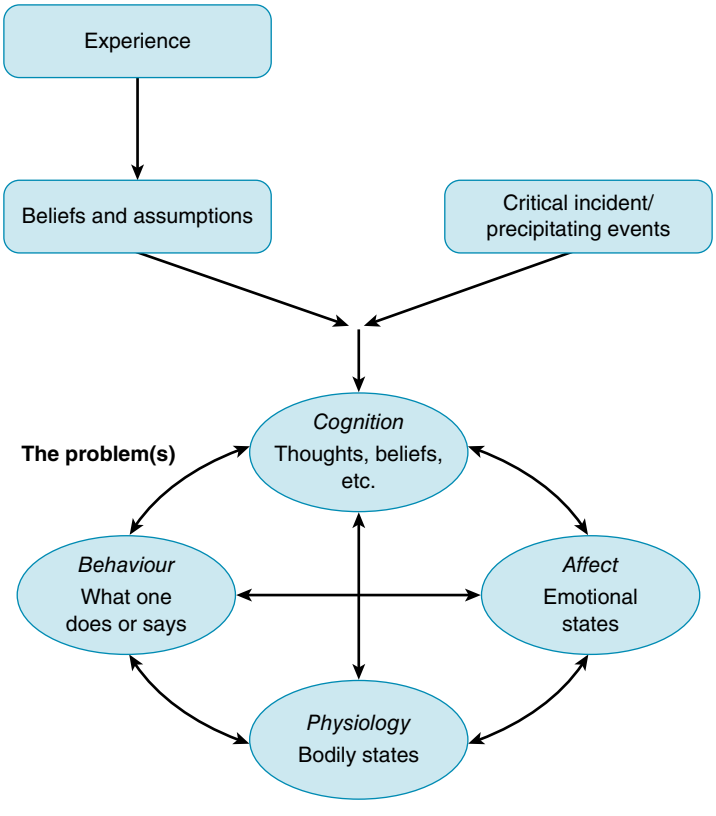


Figure 1.4 Generic problem development model

develop core beliefs and assumptions which are, to a greater or lesser extent, functional and which allow us to make sense of our world and find a way through it. There is nothing inherently pathological about this, it simply recognises that we all learn from things that happen to us. As a result of our experiences, most of us have a mixture of functional and dysfunctional beliefs, with the functional ones allowing us to cope reasonably well most of the time. Even quite dysfunctional beliefs may not cause any particular problems for many years, if at all.

However, if we encounter an event (or series of events) that violates a core belief or assumption and cannot be handled by our more helpful beliefs (sometimes called a *critical incident*), then unhelpful assumptions can become more active, negative thoughts evoked, and unpleasant emotional states such as anxiety or depression can result. The problem has been 'switched on'.

Subsequent interactions between negative thoughts, emotions, behaviour and physiological changes may then result in persisting dysfunctional patterns, and we get locked into vicious cycles or feedback loops that maintain the problem. This prevents the problem from 'switching off' once circumstances change. This is where CBT therapists look to understand the persistence of difficulties and to generate ideas about recovery through breaking cycles.

THE CURRENT STATUS OF CBT

Having earlier reviewed the history of CBT, in this section we review its current status and important contexts.

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

Perhaps the most significant development in the wider landscape of CBT since the first edition of this book, at least in England and Wales, is the explosive growth of the government's Improving Access to Psychological Therapies (IAPT: see www.iapt.nhs.uk) programme. This programme resulted from planning and lobbying led by a prominent economist and adviser to the government, Lord Layard, who became convinced that (a) mental health problems are a major source of unhappiness and loss of economic activity, and (b) that CBT could make a difference to many of the most common mental health problems (Centre for Economic Performance, 2006). He and others, especially Professors David Clark and David Richards, persuaded the government that a major investment in psychological therapy would make an impact on health, and also that such an investment would be largely self-funding, since improvements in mental health would allow a proportion of clients to return to work, thus saving on unemployment benefits.

After some pilot work in 2006, the government announced in 2007 that the IAPT programme would receive a large amount of funding, amounting to over £170 million annually by the third year. This enabled a massive increase in the provision of evidence-based psychological therapies, mainly aimed at treating anxiety and depression in primary care: the goal was to train and put into NHS services several thousand new therapists. The first of the new services and training courses were up and running by the autumn of 2008.

IAPT's first wave involved two types of CBT, because it was thought that although CBT has a strong evidence base (see later in this chapter), there was a particular shortage of qualified CBT therapists. The first category of IAPT CBT (involving 60 per cent of the new therapists) was known as 'high intensity' therapy (HI), and it offered a 'traditional' form of CBT. The second group (40 per cent of therapists) were 'low intensity' (LI) workers (since re-titled 'psychological wellbeing practitioners' or PWPs) who offered guided self-help, very brief psychological interventions, behavioural activation and exercise. Both groups' training was initially funded by the government, and consisted of a one-year in-service training course. To give you an idea of what was considered possible in a relatively short time, the HI course comprised around 65 training days over the year, whilst LI training comprised around 25 days. HI workers were already professionally qualified (nurses, psychologists, etc.), but PWPs did not need a professional mental health qualification and were expected to match their local communities more closely in terms of education, class and so on.

IAPT has adopted a stepped care approach to mental health care – a model that integrates it into existing mental health services and which is relevant beyond IAPT provisions. This is reviewed in Chapter 11. Over the last few years the IAPT approach has been extended to supporting a wider population than just those with anxiety and depressive disorders. Programmes now address child and adolescent problems, mental health problems associated with chronic physical conditions and severe mental illnesses, for example.

The impact of IAPT has been rigorously evaluated and preliminary data from the pilot sites supported the effectiveness of the programme (Clark, Layard, Smithies, Richards, Suckling & Wright, 2009) and a more recent – and highly readable – overview of outcome can be found in Layard and Clark's text (2014).

The main focus of our book is traditional CBT, or HI therapy in IAPT terms, but in many ways the LI services are the most radical part of the IAPT programme, as they deliver therapy in ways quite different from our established concept of CBT. We briefly consider some of the features of LI CBT in Chapter 16, but for more detail see Richards (2010), Bennett-Levy et al. (2010) and Papworth, Marrinan, Martin, Keegan and Chaddock (2013).

CBT COMPETENCES

Another important development since this book's first edition is the publication of the 'CBT competences framework'. This initiative, funded by the UK Department of Health, was linked to the IAPT programme and had the goal of identifying what skills a therapist needs in order to provide good-quality CBT for anxiety and depression: if we are going to train the many more CBT therapists that IAPT proposed, what exactly should we be training them to do? Roth and Pilling (2007), in consultation with an expert reference group, produced a useful mapping of competences for both LI and HI interventions. Their approach was to identify important competences through a close examination of the treatment manuals for CBT interventions that have been shown to be effective for different disorders. It seemed reasonable to suppose that since treatment based on these manuals works, then if other therapists follow the same strategies they will be providing effective treatment. Roth and Pilling produced a 'map' of competences divided into five domains:

- *Generic competences in psychological therapy*: These are the basic competences needed by a therapist from *any* school of therapy (e.g. knowledge of mental health, ability to relate to clients and so on).
- *Basic CBT competences*: Skills related to the basic structure of CBT therapies, such as agenda-setting or use of homework.
- *Specific CBT techniques*: The core treatment strategies, such as using thought records and identifying and testing thoughts and beliefs.
- *Problem-specific competences*: Approaches used in treatment programmes for particular disorders, such as Beckian CT for depression, or exposure and response prevention for OCD.
- *Meta-competences*: The 'higher level' skills that allow a therapist to make effective judgements about when to use which specific treatment strategy. This includes using the formulation to adapt treatment to an individual, dealing with difficulties during treatment and so on.

This framework is too detailed to reproduce here, but see Roth and Pilling (2007), and the CORE website cited in 'Further reading' at the end of the chapter, for more detailed information about the competences framework.

In this book we aim to introduce you to CBT skills in all these domains, with some chapters mapping particularly closely onto specific domains as follows:

- generic competences in psychological therapy – Chapters 3 and 19
- basic CBT competences – Chapters 1, 2, 5, 6 and 11
- specific CBT techniques – Chapters 7–10
- problem-specific competences – Chapters 12–15
- meta-competences – Chapters 4 and 11.

THE EMPIRICAL EVIDENCE ABOUT CBT

Finally, since we have talked about CBT's commitment to empiricism, we should consider the empirical status of CBT. Just what is the evidence that CBT is effective? And what is the evidence that CBT theory is an accurate model of human functioning?

EVIDENCE REGARDING CBT TREATMENT

Roth and Fonagy (2005), in the second edition of *What works for whom?* (their landmark summary of psychotherapy efficacy), report evidence showing that CBT is strongly supported as a therapy for most of the psychological disorders in adults that they studied, and has more support in more kinds of problem than any other therapy. Table 1.1 summarises this.

Table 1.1 Summary by the current authors (adapted from Roth & Fonagy, 2005, Ch. 17)

	Cognitive/ behaviour therapies	Interpersonal therapy	Family Interventions	Psychodynamic psychotherapy
Depression	✓	✓	❍	?
Panic/agoraphobia	✓	❍	❍	❍
Generalised anxiety disorder	✓	❍	❍	❍
Specific phobias	✓	❍	❍	❍
Social phobia	✓	❍	❍	❍
Obsessive-compulsive disorder	✓	❍	❍	❍
Post-traumatic stress disorder	✓	❍	❍	?
Anorexia	?	❍	?	?
Bulimia	✓	✓	❍	❍
(Some) personality disorders	✓	❍	❍	✓
Schizophrenia	?	❍	✓	❍
Bipolar disorder	?	❍	❍	❍

Key to summary:

✓ = Clear evidence of efficacy

? = Some limited support for efficacy

❍ = Not currently well validated (NB this indicates a lack of sufficient evidence to support efficacy; it does not necessarily imply that there is good evidence of *in*effectiveness)

In addition to this evidence of CBT's *efficacy* (i.e. that it works in tightly controlled research trials), there is also some useful evidence demonstrating its *effectiveness* (i.e. that it can also work well in ordinary clinical practice, outside specialist research centres). See, for example, Merrill, Tolbert and Wade (2003), Stuart, Treat and Wade (2000) and Westbrook and Kirk (2005).

A second useful source of evidence is the UK National Institute for Health and Clinical Excellence (NICE). This is an agency charged by the government with the task of surveying the evidence for the effectiveness of different treatments and making recommendations

about which treatments ought therefore to be made available in the National Health Service (NHS). Its guidelines on mental health conditions are periodically updated and so it is wise to visit the NICE website (www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions, accessed 22 May 2016).

NICE has produced guidelines on several major mental health problems, which include the following recommendations:

- *Depression* (NICE, 2009):
  - 'For people with persistent subthreshold depressive symptoms or mild to moderate depression, consider offering one or more of … individual guided self-help based on the principles of cognitive behavioural therapy (CBT); computerised cognitive behavioural therapy (CCBT)' (p. 9);
  - 'For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT)' (p. 9);
  - 'People with depression who are considered to be at significant risk of relapse … or who have residual symptoms, should be offered one of the following … individual CBT; … mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression' (p. 10).
- *Generalised anxiety disorder* (GAD) *and panic disorder* (NICE, 2011a): The 2004 guidelines recognised that 'interventions that have evidence for the longest duration of effect, in descending order, are: [first] cognitive behavioural therapy;' (p. 6). The 2011 guidelines recommend low intensity interventions for mild GAD and CBT/applied relaxation for established GAD.
- *Post-traumatic stress disorder* (PTSD) (NICE, 2005a): 'All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR])' (p. 4).
- *Obsessive compulsive disorder* (OCD) *and body dysmorphic disorder* (BDD) (NICE, 2005b): people with OCD or BDD should be offered CBT (including exposure and response prevention), either in group or individual format and, depending on severity and preference, also consider SSRI medication; it also says that 'when adults with OCD request forms of psychological therapy other than cognitive and/or behavioural therapies as a specific treatment for OCD … they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments' (pp. 18–21).
- *Eating disorders* (NICE, 2004b): 'Cognitive behaviour therapy for bulimia nervosa … should be offered to adults with bulimia nervosa' (p. 4); 'Cognitive behaviour therapy for binge eating disorder … should be offered to adults with binge eating disorder'(p. 5).
- *Psychosis and schizophrenia* (NICE, 2014a): Offer cognitive behavioural therapy (CBT), with or without family intervention, to those at risk and to all people with psychosis or schizophrenia. This can be in conjunction with medication.

NICE also recommends CBT in the management of other conditions such as chronic fatigue syndrome (2007), alcohol-use disorders (2011b), antenatal and post-natal mental health problems (2014b).

In summary then, at the time of writing, CBT is a psychological therapy with a most solid and wide evidence base for efficacy and effectiveness.

EVIDENCE REGARDING CBT THEORY

It is a fallacy to think that demonstrating the efficacy of a treatment proves the truth of the theory on which that treatment is based. The treatment's efficacy could be due to some combination of factors not imagined in the theory. Thus, for most of us, even a randomised controlled trial (RCT) showing that a treatment based on traditional witchcraft was effective for depression would not necessarily convince us that depression was in fact caused by evil spirits; instead we might investigate whether there was a powerful placebo effect, or perhaps whether the herbal potions used in the treatment contained a psychoactive substance. In the same way, the efficacy of CBT as a treatment does not show that CBT theory is true. In fact, the evidence for some of the fundamental theoretical ideas of CBT is more patchy than the evidence for the treatment's efficacy. Clark, Beck and Alford (1999) present a detailed consideration of the balance of scientific evidence in the case of the cognitive theory of depression. In summary, they conclude that regarding the supposed patterns of negative thinking in depression, there is evidence that there is:

- an increase in negative thinking about oneself, the future and (less clearly) the world;
- a reduction in positive thinking about the self, but this change is less marked and may be less specific to depression (in other words, the same thing also happens in other problems);
- a specific increase in thoughts and beliefs about loss and failure (more so than in people who suffer from anxiety problems).

Regarding the proposed *causal* role of negative thoughts (i.e. the suggestion that negative thinking can provoke low mood), Clark et al. (1999) conclude that there is some experimental evidence that negative self-referent thinking can indeed induce subjective, behavioural, motivational and physiological features similar to mild to moderate depression. If we experimentally provoke negative thoughts about themselves in non-depressed people, we can produce temporary states quite similar to depression.

There is also some evidence that the proposed cognitive processing biases can be identified in experiments, with evidence that in depressed people there is:

- a bias towards processing negative information relevant to themselves (but no such bias for neutral or impersonal information);
- enhanced recall of negative events, and increased negative beliefs.

Furthermore, there is evidence that these changes in processing can occur at an automatic, pre-conscious level.

The least well-supported part of the theory is the suggestion that people are vulnerable to depression because of negative beliefs that are still present in 'latent' form even when they are not depressed. Clark et al. (1999) suggest that there is a little supportive evidence for this idea, but that it has proved difficult to get clear evidence (perhaps not surprisingly, when one considers the difficulties of identifying such 'latent' beliefs experimentally).

A similar picture is found for specific CBT models for other disorders: in some areas there is good solid research support and in others the evidence is equivocal. Overall, then, the evidence is:

(a) that CBT is undoubtedly an effective treatment for many problems; and

(b) that there is support for CBT theory but that there is still room for exploring and developing this approach further in some areas.

SUMMARY

- Modern CBT is derived from the legacy of BT (with its emphasis on the importance of *behaviour change* in overcoming mental health problems) and CT (with its emphasis on understanding and changing the *meaning* of events), and Beckian CBT is also coloured by his experience of psychodynamic training (so there is recognition of the importance of the therapeutic relationship and developmental factors).
- Problems can usefully be described in terms of the interactions between four 'systems' that interface with a fifth system, namely the environment:
  - the *cognitive* system – what a person thinks, imagines, believes;
  - the *behavioural* system – what they do or say that can be directly observed by others;
  - the *affective* system – their emotions;
  - the *physiological* system – what happens to their body, such as autonomic arousal or changes in appetite.
- We distinguish three 'levels' of cognition:
  - automatic thoughts (ATs) – specific thoughts that arise spontaneously in various situations, which can have a negative effect on mood, and which are relatively accessible to consciousness;
  - underlying assumptions (UAs) – 'rules for living' that guide behaviour and expectations in a variety of situations, and which are often in *conditional* (if … then …) form;
  - core beliefs – very general beliefs about oneself, other people or the world in general, and the future, which operate across a wide range of situations but which are often not immediately conscious.

- Different kinds of psychological problem have different characteristic cognitions, in content, style or both (e.g. in anxiety there is a preoccupation with threat, and associated biases towards perceiving threat).
- There is considerable evidence that CBT can be an effective way of helping various mental health problems; and less clear, but still significant, evidence for the theories lying behind the treatment.

LEARNING EXERCISES

These learning exercises are available to download from the companion website.

REVIEW AND REFLECTION:

- **Consider what you think about the basic principles of CBT outlined in this chapter. Do they make sense to you? Are there any principles that do not fit, or do not make sense to you?**
- **What do you think of the cognitive theory underpinning CBT? Does it make sense to you? Does it fit with your clinical experience?**
- **Does it matter that the evidence for the theory of CBT is less solid than the evidence for its efficacy as a treatment?**

TAKING IT FORWARD:

- **Observe your own experience of ATs, UAs and core beliefs. Try to tune in to your thoughts and images, especially when you are upset or emotionally aroused in some way. Do your thoughts follow any of the patterns described here? What are the similarities or differences between your experience and our descriptions of different kinds of cognition?**
- **Does this observation of your own thoughts have any implications for your clinical practice?**
- **If so, how will you adapt your clinical practice?**
- **If you are drawn to this way of working, how could you start to take that forward? Are there training and supervision opportunities that you could tap into?**

FURTHER READING

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

Although now over 30 years old, the book that started the cognitive revolution is still a classic, with a real feel for the clinical realities of working with depressed clients.

Greenberger, D., & Padesky, C. (2015). *Mind over mood* (2nd ed.). New York: Guilford Press.

A well-established and best-selling self-help book now in its second edition. It is designed to assist the general public, but it is also a clear and simple introduction to CBT that many new therapists find very useful, whether or not they plan to use it with clients!

House, R., & Loewenthal, D. (Eds.). (2009). *Against and for CBT: towards a constructive dialogue?* Ross-on-Wye: PCCS Books.

A mixture of (mostly highly critical) views on the philosophy, science, ethics and politics of CBT (and by association, the IAPT programme). Often coming from a post-modernist stance, and containing some of the jargon so often associated with that approach, many of the chapters are not easy reading – but interesting if you want a different perspective.

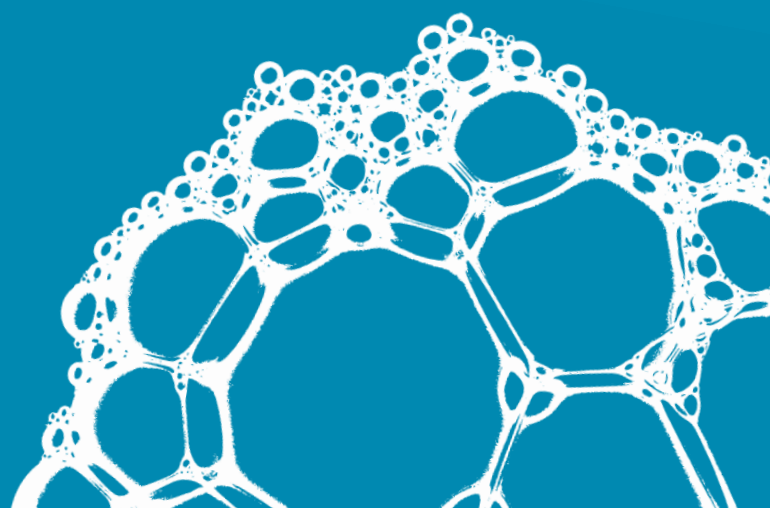
The Centre for Outcomes Research and Effectiveness (CORE) website at University College, London, under whose auspices the CBT Competences framework was developed: www.ucl.ac.uk/clinical-psychology/CORE/CBT_Framework.htm (accessed 22 May 2016).

The CORE site contains more detailed descriptions of the CBT competences for anxiety and depression, and a self-assessment tool to allow clinicians to evaluate how well their own skills match the competences.

2

DISTINCTIVE CHARACTERISTICS OF CBT

- Introduction
- Collaboration
- Structure and active engagement
- Time-limited and brief
- Empirical in approach
- Problem-oriented in approach
- Guided discovery
- Behavioural methods
- *In vivo* work
- Summaries and feedback
- Myths about CBT
- Summary
- Learning exercises
- Further reading
- Video links
  - 2.1 Capsule summaries (i)
  - 2.2 Capsule summaries (ii)
  - 2.3 Eliciting feedback (i)
  - 2.4 Eliciting feedback (ii)



INTRODUCTION

CBT has many features in common with other psychotherapies, but it is also different in important respects. In this chapter we describe the fundamental characteristics of the CBT approach, and we also explore some of the myths about CBT. We hope this is helpful for you, as well as for your clients: giving them accurate information about therapy allows them to make an informed choice about whether they want to proceed (Garfield, 1986) and it may also improve outcome (Roth & Fonagy, 2005).

CBT is distinguished by a combination of characteristics, which can be summarised as:

- collaborative;
- structured and active;
- time-limited and brief;
- empirical;
- problem-oriented.

CBT also frequently employs the techniques of guided discovery, behavioural methods, *in vivo* work, summaries and feedback. Other psychotherapies might well embrace such techniques and approaches but they are particularly prominent in CBT.

COLLABORATION

CBT is fundamentally a *collaborative* project between therapist and client or patient. Both are active participants, with their own areas of expertise: the therapist has knowledge about effective ways to solve problems, and the client has expertise in his own experience of his problems. This collaborative emphasis may be different from what the client expected of therapy, and so it is important to clarify what he is anticipating so that you can establish a shared view from the outset. Part of the initial introduction to therapy would include a statement about the client's crucial role. For example, you might say:

> We each have an important role in the treatment. I know quite a lot about CBT, and about how particular sorts of problem can present difficulties for people. However, you know very much more than I do about the details of how your problem affects you, and it is this knowledge that will allow us to understand and gradually change the situation for you. This really is a joint enterprise.

This also implies that you cannot be expected to know all of the answers all of the time. There will be times when you are unsure, and then you can always ask your client for clarification, more information, or their view of the situation.

A woman described a vivid dream to her therapist and asked, 'What am I supposed to make of that?' The therapist was not confident in his ability to interpret dreams but he was curious to understand what lay behind the question, so he said: 'I can't interpret your dream or speculate on its meaning, but I can help you understand how it affected you.'

Remember that CBT encourages openness and honesty between therapist and client: be overt about what you are doing and why, and ask for honest feedback about what is helpful and what is not.

Following the conversation above, the therapist simply enquired: 'How does that sound to you?' and he discovered that his client was a little disappointed not to be told what her dream meant but she was prepared to go along with him to see if it was helpful. He then posed questions to explore the personal impact of the dream: 'What do you think was important about your having that dream?' and 'How did it leave you feeling?' and so on. Afterwards they debriefed this exploration and the therapist asked: 'How did you feel about our looking at your view of the dream, rather than my answering your initial question directly?' and 'What did you learn from doing this?' The client fed back that she had found it surprisingly enlightening – this experience then helped to support the collaborative way of working.

Collaboration should develop as treatment proceeds. Encourage your client gradually to take a more active role in setting agendas, devising homework and giving feedback. Enhance this by being genuinely respectful and by fostering the sense that he is becoming his own therapist. The hope is that clients will leave therapy as skilled CBT practitioners, so they are encouraged to use the approach independently, and to be prepared should a relapse occur in the future (see Chapter 6).

STRUCTURE AND ACTIVE ENGAGEMENT

The problem-focused and structured nature of CBT requires the therapist to work with the client to maintain structure in the sessions. For example, at the beginning of each session, we set an explicit, shared agenda, and then largely stick to it (see Chapter 11, which elaborates on the process of agenda-setting).

CBT therapists are *actively* engaged with the client and may talk more than in some other therapies – perhaps as much as 50 per cent of the time in the early stages. This can feel onerous to new therapists. However, much of your input is in the form of questions, and the way the session develops is the result of a joint effort. In the early stages of therapy, the content of sessions will be directed to a greater extent by the therapist, but responsibility is increasingly picked up by the client as sessions progress. For example, homework tasks are likely to be devised by you at first, but as treatment proceeds, your clients will have a greater role in setting up assignments for subsequent meetings.

A woman had obsessional problems focused on sticking to the rules, not falling foul of authority, and complying absolutely with official requirements. She had more generalised beliefs about always needing to do the right thing, and the likelihood of rejection if she stepped out of line. She had had eight treatment sessions and was taking more responsibility for the content of sessions when the following discussion took place:

Therapist: You say that doing something for yourself, particularly for pleasure, would be very difficult for you. How do you think you might take this forward, so that we could find out more about how you feel, and what beliefs are operating in situations like that? [*therapist setting stage for experiment*]

Client: Well, my friend has twice invited me to go to a jewellery class with her, and I would love to go, but both times I said that I had too much on … and I did, but I would have found it difficult to say yes, even if I'd got nothing to do. So I suppose I could go with her, and see what happened.

Therapist: For our purposes, what do you think you could look out for?

Client: Well, I would need to know what feelings I had, and what beliefs seemed to be relevant.

Therapist: Anything else that would be useful to look out for?

Client: I suppose what I felt like afterwards, because that is when the guilt is likely to kick in.

Therapist: Let's include that then. What sort of diary form shall we set up?

The extent to which the client determines the content of sessions is partly a function of timing and his personality, beliefs and attitudes. An autonomous person might assume control from early in treatment, whereas a more dependent person will benefit from a slower handover of responsibility and will probably need more coaching.

TIME-LIMITED AND BRIEF

Both clients and commissioners of services find CBT attractive partly because it is often relatively brief. In this context, 'brief' means somewhere between six and 20 sessions. The number of sessions is guided by treatment trials concerning the target problem but is also influenced by the specifics of the problem and the client, as well as available resources. As resources are often scarce, it is important to help people efficiently, and the structure and focus of CBT contribute to achieving that. Table 2.1 gives some suggestions about possible lengths of treatment for different types of problem.

Evidence does not suggest that long treatments necessarily do better than shorter ones (Baldwin, Berkerjon, Atkins, Olsen & Nielson, 2009), and neither do clients who have been on long waiting lists necessarily require an equally lengthy treatment. For therapists used to other treatment approaches, the rapid move from one or two sessions of assessment and formulation into a six- or eight-session therapy may feel uncomfortably rushed, but this is likely to become less difficult as you become more familiar with the approach.