3
Drawing on Cognitive Behavioural Therapy in Social Work Practice

Key Concepts
- Cognitive Schema
- Automatic Thoughts
- Connection between Assumptions, Thoughts, Feelings and Behaviour

Key Theorists and Practitioners
- Kelly
- Beck
- Ellis

Introduction
Cognitive behavioural models of therapeutic intervention have a well-established place in practice for those working with vulnerable people. For this reason, the approach has been included as integral to this book. However, the model can only be successfully incorporated into practice with an understanding of the theoretical underpinnings to the approach. This chapter has a weightier emphasis on the theoretical components to the approach compared with most other models incorporated in this book. There is as much of an emphasis on tracking and understanding service user thought processes and how they lead to certain behavioural responses as there is to using techniques to change them. This focus on ‘understanding’ thoughts and feelings is reflected in the content of this chapter.

This chapter aims to provide those in social work practice with a broad understanding of the principal components that contribute to cognitive behavioural therapies and develop these aspects into how social workers can use these skills in practice to facilitate change. As the emphasis of this approach is on individual functioning rather than social factors that can directly contribute to emotional and behavioural problems, as social workers we need to be equally mindful of environmental influences to problems, such as poverty and oppression.
Within this chapter are several diagrammatic models to highlight the circular link between how we and how we behave. The theoretical aspects to the approach, as in other chapters, are linked to case studies and to some of the skills that we can develop to use this approach in a social work application.

**Theoretical Underpinnings of Cognitive Behavioural Therapy**

Cognitive behavioural therapy derives from an integration of two therapies, cognitive therapy and behavioural therapy, an amalgamation of which started in the mid-1970s. Behaviourism refers to the ways in which behavioural outcomes can be manipulated to either increase or decrease as a result of the consequences that occur. Cognitive theories are concerned with thought processes that impact on individual functioning, leading to undesirable changes in mood and emotion.

Behavioural therapies were the first to develop, beginning with Adler and Watson in the early 1900s, followed by Skinner in the mid-1940s. These therapies moved away from the dominance of psychoanalysis to develop learning theories and they became almost revolutionary in the therapeutic field. Behaviourism in its infancy included classical conditioning, the learning theory that behaviour is conditioned by repeated exposure to stimuli of the same nature. Behaviour becomes conditioned to react to the expectation of an event, when corresponding stimuli are experienced. These events include the well-documented experiments by Pavlov (Hawton et al., 1995) conditioning a dog to respond to a bell by salivating. The bell was paired with food at first and then rung without food. The food led to the dog salivating as an unconditional response, linked to hearing to the bell. As the bell was repeated with no association with food, the learned behaviour became extinguished.

Operant Conditioning (Skinner) developed from this starting point. Hawton and colleagues (1995) define this as “… the “Law of Effect” … behaviour that is followed by satisfying consequences will tend to be repeated and behaviour that is followed by unpleasant consequences will occur less frequently’. Behaviour followed by satisfying consequences and thus increased is termed as being ‘positively reinforced’. Reinforcement and thus an increase in a form of behaviour can also result as an outcome of an unpleasant but expected consequence not occurring. This is termed negative reinforcement.

In working directly with people, Behaviourism became a forerunner of work with problems such as anxiety and low mood and later with more severe mental health problems, including psychosis, although the results of research into what reinforced changes and how appears to have been hotly debated.

Cognitive therapies became integrated into behaviourist therapeutic techniques as the limitations of a purely behavioural approach became apparent. Behavioural therapies did not address the thought processes linked to emotional influences on behaviour. Concepts such as motivation and general mood, whether optimistic or pessimistic regarding the future, could not be directly explained by behavioural theories. Rational emotive therapy (Ellis, 1962, 1999) developed alongside cognitive therapy
(Beck, 1970) to offer theoretical ideas that allowed an individual’s thought processes and the behavioural and emotional consequences that followed to be more easily understood.

Blackburn and Davidson (1995) outline the way in which an individual will interpret an event through a filter of ‘a priori structures of knowledge’. That is, interpretations of events are filtered through past experience, socio-cultural history and the prevailing mood of an individual at any given time. Cognitive theories recognise the influence of early experiences that shape individual belief systems that in turn shape thinking. However, contrary to the focus of psychoanalytic psychotherapy, cognitive therapy is concerned with thought processes that occur in the present and thus the therapies tend to be structured and time-limited in their nature.

As the two therapies integrated, there became a greater recognition that thought processes strongly influence behaviour, either in motivating an individual toward a course of action or leading to behaviour that results in avoidance of certain situations or experiences. The two therapies have not become one. However, cognitive therapies often work alongside behavioural techniques to focus on changing both thought processes and behavioural outcomes where either or both cause some form of distress for an individual.

This integrated approach does not discount the systemic nature of problems, such as environmental influences that continue to reinforce thinking and behaviour. Rather, environmental experiences are viewed as causal factors for problems in conjunction with interpersonal relationships and individual traits. A combination of these factors, in various degrees, can lead to one individual experiencing emotional and behavioural problems where another might not. Resilience to problems in individuals is not discussed here, but equally can give insight into the differing extent to which people experience emotional problems as a result of their experience.

Central Concepts

Cognitive Schemata

Beck’s ‘schemata’ or ‘schema’ (Beck & Emery, 1985) is defined by Blackburn and Davidson (1995) as ‘stable knowledge structures which represent all of an individual’s knowledge about himself [sic] and his world’. Knowledge structures consist of an individual’s beliefs about people and the theories we hold about the actions people might take in given circumstances. They also consist of theories about the world around us and about ourselves, including our self-image and our sense of worth. Beck’s theory about schemata was influenced by Kelly’s (1955) ‘personal constructs’.

The development of cognitive schemata begins in early infancy with experiences that are given core, or established, meaning over time (Beck & Emery, 1985). That is, as experiences build on one another, a set of beliefs and theories begins to develop for each individual that acts as a type of lens through which people, relationships and the world in general are perceived. Experience becomes subjective rather than objective.
It is viewed through structurally developing filters that allow interpretation of events and assumptions about the meaning of each experience to occur.

As infants grow older, these experiences continue to build and shape the way in which the core structures are formed. In childhood and early adolescence, these structures or schemata remain pliable enough to be changed and shaped in accordance with different experience that challenge core meaning structures already formed. However, these core structures become consolidated during adolescence and more fixed in early adulthood (Friedberg & McClure, 2002). Consequently, working with individuals to change problematic core beliefs is progressively more difficult as a child matures, often requiring direct therapeutic intervention by adulthood when significant emotional problems arise. Conversely, changing environmental experiences for younger children has a greater probability of altering the knowledge structures that shape the interpretation of experience.

Using this theory to map likelihood of generating changes in children’s core knowledge structures that shape emotional health through the filtering of experience could be seen on a continuum. The younger the child, the more likely that changing environmental and interpersonal experiences will positively impact on the development of that child’s core cognitive schemata. The older the child, or the more severe the nature of the early adverse experience, the less effective changing the environment alone would likely to be in creating more positive core beliefs about the world and the self.

The nature of schematic material contained within these core structures is believed to consist of early-experience non-verbal images alongside verbal material that combines over time to develop an ‘attributional style’. This attributional style relates to an individual’s tendency to view the world and/or the self either positively or negatively. While this style is formed in childhood, it might not be until adulthood that the effects of the attributional style emerge through mood, thought patterns and behaviour. In general, schemata lies dormant until a situation perceived as a stressor triggers automatic thoughts that are based on schematic interpretation of the meaning of that situation. These automatic thoughts that arise are skewed by negative assumptions about the situation, as opposed to more positive assumptions, deriving from the core beliefs in someone struggling with emotional problems.
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He presented as though his life was completely out of his control and as though he had to endure difficulties with resigned passivity. From time to time, life events would build to become overwhelming and he would become extremely angry to the point of rage. It was during one of these rages that Aaron had hit his son. Gillian observed that Aaron appeared to have a negative attributional style.

Social Work Application

When we meet with vulnerable people who often have had adverse experiences and difficult personal relationships, it is probable that many of these people will have cognitive schemas that leave them feeling anxious and/or hopeless about the future. Developing our knowledge of this theoretical concept can allow us to make sense of how a set of core beliefs and theories about themselves and their world might have formed. Often we can be perplexed about behaviours displayed by people, especially if on the surface these behaviours do not appear to fit with the social context in which they live. We can often find ourselves explaining away certain behaviours when we link them to poverty, deprivation and oppression. However, these experiences might not be visible nor found in the present. It is our responsibility as social workers to think about the environmental context in which someone exists and work to empower an individual to improve it wherever possible. However, when historical experience is influencing and impairing life experience in the present for service users, thinking about cognitive schemata can be a useful starting point for change.

Skills Component

- Develop an understanding of the formation of core knowledge structures that consolidate through adolescence to become an attributional style
- Use listening skills in communication with individuals to track themes of negativity, hopelessness or fear in conversation
- Assist individuals to share their views of life and life experience relating to past, present and future

Automatic Thoughts

Automatic thoughts are the thoughts based on assumptions that immediately occur, like a habitual reflex action, following a stressor that is perceived and interpreted as either negative or as a threat (Beck, 1976). Ellis (1999) refers to these as ‘self-statements’. Automatic thoughts occur in every individual and are based upon our individual
cognitive schemata. Each of us, therefore, has ‘cognitive vulnerabilities’. Whether automatic thoughts regarding events develop into severe emotional problems is not a matter of health versus pathology. Rather, whether automatic thoughts are problematic depends on a subjective measure regarding the frequency of these thoughts and level of intrusion on day-to-day functionality. The more unhelpful assumptions that occur as automatic thoughts, the more vulnerable a person is likely to be to experiencing emotional and behavioural problems. Also, the more likely it is that a wider range of stressors will trigger these unhelpful automatic thoughts.

For example, a woman who believes that traffic lights do not adequately control traffic flow, and whose core beliefs include a view of the world in general and traffic specifically as unsafe and unpredictable, finds that every time she is a passenger in a car and goes through traffic lights, she starts to have panicky feelings. Tracing her automatic thoughts at this time reveals assumptions that traffic chaos prevails at junctions, which generates her fear that she is going to die in a car accident when going through a set of traffic lights. The worst possible outcome is thus anticipated, referred to as catastrophising. This leads her to avoid forms of transport, which restricts her lifestyle to some extent. Other than a fear of roads, this woman might not have significant problems in day-to-day living, although her core beliefs about the unsafe nature of the world would probably become activated in stressful situations.

The degree of intrusiveness by unhelpful assumptions and automatic thoughts will vary from person to person. In social work practice we acknowledge that individuals with more severe emotional problems are not ‘pathologically’ different from those of us without, but that some of us are more cognitively vulnerable than others.

As Gillian and Aaron spent ‘therapeutic’ time together following the registration of the children on the Child Protection Register, Gillian recognised that Aaron seemed to be preoccupied with the future being bleak for him and his family as a consequence of Social Services involvement. He interpreted the registration of the children as the ‘step before they are taken away’. While Gillian used listening skills to hear and acknowledge Aaron’s view, she hypothesised that this was not enough to facilitate change for this family. Working with Aaron to track some of his automatic thoughts revealed that when the children, especially the youngest, became argumentative, he felt powerless to manage the situation. He would shout and try to reason with them but it made no impact on their behaviour. He believed this was an indication of his failure and inadequacy as a person and would give up trying. The automatic thoughts that surfaced as a result of these beliefs included ‘I am a useless father’; ‘I am a useless husband’; ‘there is no point trying’; ‘I don’t know what to do’; ‘nothing will ever change’.

Social Work Application

The nature of social work requires us to have conversations with service users and use communication skills as the central tool in bringing about change.
Through our conversations with people, we can become attuned to listening for themes as to how beliefs about the self and the world can translate into specific assumptions that influence feelings and behaviour. As with schemata, knowledge of the theory relating to the formation and impact of automatic thoughts can give us direction to assist a person to make changes in their lives. We might find ourselves working to create opportunities for different experiences to the ones service users have day-to-day, such as empowering a socially isolated woman to attend a group of other women in similar circumstances. We might then become frustrated that the woman does not attend, even though she seemed willing at the time of discussion about it.

While individual choice needs to be respected, it could be that negative automatic thoughts about how she would perform in a group, whether the group would accept her and whether it would help could all limit the extent different opportunities can be utilised. Making sense of automatic thoughts in this respect could more helpfully inform our thinking about the woman not taking up services than perhaps believing she is resistant to change. Using this concept could also empower us to adapt our practice and care plans that we formulate to better suit the needs of individuals.

Skills Component

- Develop an understanding of how automatic thoughts are generated and the impact they can have on choices and behaviour
- View resistance to intervention as indicative of an individual's automatic thoughts about the nature of the work
- Recognise where automatic thoughts are having a negative impact on a service user's life by enquiring about what stands in the way of change, i.e. fear that 'everyone will laugh at me', 'there is no point'
- Incorporate conversations regarding these thoughts and their impact into communication and intervention (see below)

Cognitive Distortion

As above, we can understand from cognitive behavioural theories that stressful situations trigger assumptions and then automatic thoughts that occur like reflexes to provide us with a filtered interpretation of an event. All events that we experience are not objective, free from interpretation. Rather, they are individually subjective, as made sense of through this filter of previous experience and interpretation. Automatic thoughts become unhelpful when they distort an experience to fit with the core belief system, the cognitive schemata.
For example, a child who has been removed from their family-of-origin due to neglect and placed with foster carers might receive a higher level of care and nurturing from the carers. However, initially when moving to the new family, the child will be viewing the care received through the filter of their core beliefs, albeit that these core beliefs are not yet consolidated. If the new experiences of nurturing do not fit with the child’s beliefs and assumptions about how adults behave, it is likely that nurturing experiences will be rejected and given less weight than more neglectful experiences. Thus the cognitions or thought processes become distorted.

As the cognitive schemata are not consolidated in children, it is likely that different experiences alone would change some of the core beliefs of a child about adult behaviour. However, in adults, these beliefs being more fixed often require some form of direct intervention to enable changes to occur. Thus an adult who is consistently critical of services might be filtering these experiences through their core beliefs to negate or distort more positive experience. However, using a post-modern perspective to critique this model, we might remind ourselves of the difficulties in defining ‘reality’, and so what is ‘real’ to one person will be very different to what is ‘real’ to another. We might also question the definition of ‘distortion’. On this basis, only when thinking patterns negatively impact on a person’s life to the point where it is either harmful to themselves, to others or where the person is requesting help, can we justifiably intervene to try to change unhelpful assumptions about life.

With Aaron, his thoughts and perceptions of his family had led him to a violent act that required statutory intervention. He had filtered his experience of family life to become wholly negative; a view that was not shared by other members of his family.

Aaron’s youngest child had been mostly well behaved at home, according to Jan, his partner. Jan noticed that her relationship with Aaron was often very warm although Aaron would withdraw ‘into himself’ and would be difficult to talk to for days at a time. However, Aaron could not recognise any times when he was relating well to his children or his partner. He would filter out these experiences as ‘meaningless’. He discounted these experiences, which left his core beliefs and theories about himself and the world intact.

Social Work Application

As we continue to communicate with service users about their lives and their behaviours, we can become aware of when some life experiences are given recognition and when some are dismissed. Other chapters give consideration to how we construct reality and how dominant social discourses filter experience to exclude opinions and beliefs of minority groups. This is not to dismiss the fundamental social work principle that experience is highly subjective and that we cannot impose our view of truth and reality on another person. Aaron has a right to his view of ‘reality’, although by filtering out more
positive interactions with his family that are experienced by others, he maintains his belief about his worthless status within the family. This belief had been a contributing factor to a serious incident that left a child injured. For practice to be ethical, Aaron would need to give consent to a social worker exploring with him unhelpful assumptions about life that do not seem to fit with the specific environment in which he lives.

There needs to be caution exercised here when contemplating whether a person’s experience is ‘distorted’. We could be dismissing experience of abuse in various forms if we interpret a person’s negative statements about life as evidence of cognitive distortion. In social work practice, we are constantly thinking about risk and risk management. To effectively use this concept, we need to view statements made in the light of other information before making an informed judgement as to whether a cognitive behavioural approach would be in the best interests of a service user. If a person is experiencing a form of abuse, then viewing assumptions as distortions would undermine a person’s view of reality and their confidence in their own perceptions. It could also give a message that the abuse is acceptable behaviour and that we are colluding with the perpetrator by ignoring it.

Skills Component

• Listen to unhelpful assumptions made consistently by individuals to track whether they appear to be dismissive of more positive feedback from others or of their successes
• Be mindful of theoretical models that introduce the individual and social construct of reality
• Exercise caution in viewing all negative statements about others or the self as ‘distortions’

Cognitive Behavioural Model

This model demonstrates the way in which thoughts are generated, then established, leading to emotional, behavioural and physiological reactions. The cognitive behavioural model of emotional and behavioural problems helps explain the development of problems over time and how these problems might impact upon several significant areas of a person’s life.

Content-specificity Hypothesis

Content-specificity hypothesis is a term for a framework for recognising automatic thoughts that maintain and perpetuate schema or core beliefs and theories. Cognitive
Previous Experience
Experience of neglect and punitive parenting in childhood
Perception that adults in close relationships are untrustworthy

Formation of Unhelpful Assumptions
‘Adults will always ignore me or hurt me’
‘I am not worthy of being cared for’
‘I am bad’
‘I am not lovable’

Critical Incident
A new partner becomes physically aggressive

Activation of Assumptions

Negative Automatic Thoughts/Imagery
‘I deserve this’
‘I should not have annoyed her’

LOW MOOD AND RELATIONSHIP ANXIETY

Behavioural
Remains in an abusive relationship

Affective
Feeling flat
Hopeless
Low motivation

Physiological
Increased arousal
Sleep disturbance

Cognitive
Self-critical thoughts
Focus self-blame

Source: Adapted from Scott et al. (1991) and Hawton et al. (1995).
theory is based upon the premise that different emotional states result from specific organisations of cognitions that are unique to each state. Thus characteristics in thought and in beliefs are grouped into several distinct groups, such as depressive or anxiety states. As social work practitioners, we are not concerned with the grouping of individuals with a view to labelling them or 'medicalising' their presentation. However, awareness of the theory of how certain thought processes are linked through research to certain states of mood and resultant behaviour can assist us with choosing the most effective form of communication to assist individuals with working towards change.

Several hypotheses are useful for social workers to know. The ‘negative cognitive triad’ (Beck, 1976) links people with chronic low mood experiencing unsatisfactory events by criticising and blaming the self, even when external factors were outside of that individual’s control. Thus a ‘self-critical’ view of problems and preoccupation with past (unfavourable) events lead a person towards a generally pessimistic view of the future.

In contrast, problems with anxiety have a different hypothesis in cognitive therapy. The core structures of cognitions or thoughts are developed to be more future-orientated in people with anxiety problems. The content-specific hypothesis for anxiety is that people will be preoccupied with potential dangers that the future could bring but have not as yet occurred. Catastrophising about the worst likely future outcome of a given situation, regardless of other information that might suggest the worst outcome is unlikely, is also a key feature of this hypothesis.

Without falling into the diagnostic/symptomatic arena, knowledge of content-specificity hypotheses for emotional problems that are often part of a complex picture of vulnerable individuals or families within social work practice can enhance our practice threefold. Firstly, we can hone our use of counselling skills for communicating about emotional problems. Secondly, we can expand our understanding of the development of emotional problems over time to make sense of the evolution of low mood and anxiety. Thirdly, we can be more selective about the techniques we require to draw on to bring about change with people.

Aaron had, over many years probably originating in his early experiences, developed core beliefs that, through his thoughts, culminated in his negative view of himself, of others and of his future. Gillian was able to recognise the pattern of these negative thoughts, which offered her a focus for choosing certain therapeutic skills over others to facilitate change. Aaron was clear regarding his remorse for assaulting his youngest child and was able to take responsibility for his actions. He also demonstrated commitment to the children in that he did not want to lose contact with them. While he did not ask for therapeutic intervention for his low mood, Aaron’s motivation for working
therapeutically with Gillian was to maintain contact with his children. Gillian used her knowledge of cognitive behavioural approaches to assist her to communicate effectively about the problems and to use this communication to bring about change. Aaron gave consent to be engaged in ongoing work and so progress began. As Gillian assisted Aaron to identify some of the triggers that maintain his low mood, including his perception of events, his feeling of powerlessness reduced alongside the extent of his rage.

Social Work Application

As previously stated, the social work role does not take us into the domain of categorising problems into groups that some other disciplines might label as illness or disorder. Content-specificity hypothesis could be used by some disciplines as a diagnostic tool. However, for social workers we can use the concept of common themes with thought patterns to assist us with targeting communication and intervention at a level that best suits the problem. We do not need to be caught up in the stigmatising implications of labelling problems to do this. We can selectively use language that is inclusive and empowering rather than categorising individuals as having an intrinsic problem. We can refer to an individual having problems with low mood or worrying and work with people to limit the impact these problems have on social functioning through considered therapeutic intervention. This does not require a label to allow this type of work to be valid.

Skills Component

- Become familiar with the general patterns of thought development that influence perceptions of the past, present and future
- Work with people to explore these patterns through the therapeutic relationship
- Use language that defines the nature of the problem rather than labelling an individual in general and stigmatising terms

Techniques used in Cognitive Behavioural Approaches

The Therapeutic Relationship

In social work practice, we are first and foremost interested in engaging with service users in a working relationship. In many forms of counselling and therapy, including
cognitive behavioural approaches, this process is described as the therapeutic relationship. Wills and Sanders (2002) indicate that the emphasis on the therapeutic relationship has not always historically been a core component of this approach: the technical aspects being favoured. Wills and Sanders, among other theorists and practitioners, have recognised this lack and emphasise the importance of the engagement process, more fitting with a social work model.

As many people with chronic and entrenched problems are likely to have interpersonal difficulties, the need for nurturing of the therapeutic relationship cannot be understated. Thus some of the features of Rogers’ work (1951, 1959, 1986) (see Chapter 2), including warmth, genuineness and unconditional positive regard, have been incorporated into cognitive behavioural approaches. The requirement for a transparency, i.e. avoiding hidden agendas, is important for a trusting relationship to be formed. Social workers in various fields often have grave concerns regarding an individual or a family’s situation and being open and transparent about serious concerns is often a challenge. However, to be genuine in our interactions with a person, we need to develop our ability to assertively state our position regarding concerns in order that we can be transparent in our working relationship.

Collaboration is an aspect of the working relationship that requires all of the above features but acknowledges the reciprocal nature of the therapeutic alliance. Often in social work practice we demonstrate enthusiasm with regard to developing a positive working relationship, especially in statutory work where service users have a legal obligation to work with us. Collaboration, however, involves a step-by-step building of a relationship, involving feedback and reflection, as well as a sense of both parties working towards a common goal. This approach removes the emphasis on the service user alone being expected to make changes that can be perceived to be dictated by another, i.e. the legal system, child protection procedures. Rather, the collaboration between the worker and the service user generates the changes, without reducing the responsibility for individual behaviour being removed from the service user.

When Gillian first met with Aaron and his family, her social work role, in this instance regarding child protection concerns, required that she engaged with the family and was explicit about her involvement. This initially evoked an angry response from Aaron and his partner and so Gillian and her colleague used communication skills to remain calm and non-threatening while retaining an assertive stance regarding the social work role. As the crisis was addressed, Gillian’s transparency regarding her agenda and her continuing reliability, consistency and respect for the parents through the investigative process had begun to establish a level of trust and collaboration. Gillian was fully aware of the need for collaborative understanding to be established before she could work with the parents to bring about change.

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Social Work Application

The therapeutic or working relationship is fundamental to the nature of social work practice. As social work practice has evolved over the twentieth and now twenty-first centuries, the core element to practice remains as this relationship. As we meet with individuals, we emphasise the importance of this relationship through the engagement process. Engagement means more than a service user being available for visits or meetings. It is based upon a transparency of role and purpose for involvement, respect through reliability and consistency and developing a level of mutual trust. A truly collaborative working relationship maintains clear boundaries to behaviour, including the level at which a practitioner will disclose elements about the self. As these boundaries become clear and accepted, the relationship can provide a secure enough temporary base within which difficult experiences and feelings can be explored. This is covered in greater depth in Chapter 4.

Skills Component

• Prioritise the importance of forming a working relationship at the beginning of any work
• Maintain engagement through continuing attention to the therapeutic relationship as intervention progresses
• Be clear about the role and purpose of intervention before meeting with a service user to facilitate transparency
• Give attention to the foundations to engagement, including time keeping, reliability and consistency of approach
• Enable the service user to have an active role in the working relationship by drawing on listening skills

Problem Identification and Social Work Assessment

As social workers, we are concerned with the assessment process to make sense of what factors might be contributing to an individual’s difficulties. A broader social work assessment framework (Parker & Bradley, 2003) requires us to take account of social, economic, political and relationship factors as well as individual patterns of thinking and behaviour. The cognitive behavioural model allows us to focus in on thoughts and behaviour after considering the contributing environmental factors such as the impact of poverty and deprivation, significant life events and history. Thus identifying problems for social work practitioners using this model would most likely be useful as part of a more general assessment.
For adults, it might be easier for them to identify problems related to low mood or anxiety. For children and young people, this is more complex. Often it is not children themselves who request services or who are developmentally able to hypothesise regarding the impact of their problems on their own lives or on others. Using this model, problem identification is related to tracking where and when unhelpful emotional and behavioural responses to situations in life impair functioning as social and emotional beings. The model requires an approach that targets specific behavioural and emotional responses using a framework of techniques to bring about change in a time-limited period. Most adults are able to identify these problematic areas. However, with children and young people, a greater emphasis is required on the engagement process and on a more practical approach to identify feelings and worries, such as using simple worksheets, pictures and toys to allow children to communicate their feelings and worries in a non-directive manner (Geldard & Geldard, 2002).

An assumption is made, as with any other therapeutic model, that the practitioner will offer a warm and uncritical, responsive working relationship to generate trust and open participation in discussion regarding the nature of problems. This closely fits with the requirement for social workers to develop working relationships with people as part of the engagement process.

Problem identification in this instance was threefold. For Gillian, a social worker using child protection policies and the legal system as a framework, the problem was the contributing factors that led to a child being assaulted. The problem for Aaron was that he believed the world was against him and that he was powerless to make any changes, other than when he became angry, and people, including his children, listened to him through fear. From a cognitive behavioural perspective, the problem was related to Aaron’s negative attributional style, based on his core beliefs about the world. Gillian was able to hold the three angles to problem identification enough to satisfy the legal and local policy requirements to protect children from further harm – this being her first priority. She was also able to hold Aaron’s view of the problem in mind, him being the perpetrator of the physical abuse, and the focus of change if he was to remain in contact with his children. She did this by listening to his views and accepting them, albeit that they could not override child protection requirements. Following the initial crisis, Gillian used cognitive behavioural theories to work with Aaron regarding his core beliefs that governed his interpretation of experience, with a view to facilitating change for him and for his family.

Social Work Application

As part of the assessment process, problem identification is a fundamental part. We need to give consideration to what is a problem for whom. Often

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those who refer vulnerable people for social work services have concerns about the behaviour or social functioning of an individual. They will have identified a problem which they hope social work practitioners will be able to resolve. This does not always fit with an individual’s view of a problem, however. Before problem identification can be undertaken from a cognitive behavioural perspective, thought needs to be given to who believes what is a problem and whether there are any requirements of the legal system that would influence how much choice an individual has and what are the consequences if the problem is not addressed.

Skills Component

- Identify who is most concerned about the service user and who is most motivated for problems to be resolved
- Consider the demands of the legal system in problem identification
- Seek permission from the service user to explore problems relating to feelings and behaviour using this approach
- Explore the consequences that denial of permission for intervention might have, i.e. in relation to the legal system or child protection systems
- Accept that cognitive behavioural approaches can be viewed as intrusive to some people who are not ready or willing to examine the contributory factors to their mood or behaviour

Using the Cognitive Behavioural Model in Practice

Outlined above is the cognitive behavioural model. Incorporating the model into practice requires a timely coordination of intervention in social work practice, especially when statutory matters require primary consideration.

Following matters relating to child protection being undertaken, Gillian embarked upon a programme of work with Aaron to identify some of the thought processes and behavioural consequences that led to the assault of his child. Using the cognitive behavioural model, she found that working collaboratively with him to make sense of events unveiled the contributing factors.

Aaron had had on the surface an unproblematic childhood. However, when he gave more thought to his experience, he recognised that, in his busy family of four children and with him being the quieter third child, he often found that he
did not have a voice that was heard. He found that he would withdraw rather than try to let his family know his thoughts about matters. This would lead to feelings of anger and resentment regarding his family. He began to believe that his opinion was not important and that he was worthless as an individual.

This led to several unhelpful assumptions developing that he would make about himself, other people and about the world in general. He assumed that his opinion about ‘things’ was less worthwhile than those of other people. He assumed that people in general would not listen to him unless he became really angry. He assumed that the world was a busy, fast place that did not allow a space for his opinions to exist. He assumed that he had no skills to change this and that he was completely powerless for life to be experienced differently.

A critical incident had occurred. Aaron’s partner had been promoted in her place of employment at the same time that his youngest son had been especially challenging around times to go to bed. This ‘critical incident’ on the surface might not appear to be out of the ordinary but for Aaron, who was not working and having his authority as a parent challenged by his son, became critical enough to activate his assumptions about life. Negative assumptions including ‘I am worthless’, ‘no one listens to me’ and ‘everyone else has their say heard’ generated several cognitive, behavioural and physiological responses.

Aaron’s cognitive response was increasing thoughts of his own worthlessness and of others’ disregard for him; his physiological response was an increase in arousal – raised heart rate and ‘fire’ in his muscles; his affective response was feelings of overwhelming anger leading to rage; and behaviourally this manifested in the assault of his son.

Gillian effectively used the model to enable Aaron to make sense of his actions and create some specific areas whereby changes could be made.

**Social Work Application**

Once a service user has given permission to explore the various factors that generate unhelpful thoughts and feelings, this model can be used to make sense of how early experience can link with core beliefs and thus assumptions that directly impact on present perceptions of events and their outcomes. We might debate how useful actually seeing the model might be for service users or whether the practitioner uses it as a therapeutic map from which to ask questions and make sense of reactions to experience. Since the emphasis of
Cognitive Behavioural Assessment

The focus of this chapter, or indeed this book, is to provide practitioners in social work with a range of counselling skills drawn from several therapeutic models. Models for assessment in social work can be found in other literature (Milner & O’Byrne, 2002a); however, the emphasis on tracking the details of emotional and behavioural problems within this model requires some attention being given to cognitive behavioural assessment.

The first concern with a cognitive behavioural assessment is to track the onset of the problem: for example, when did the first experience of anxiety emerge? The problem could either have had a gradual onset where the problem has worsened or developed suddenly, usually following a traumatic experience. We would be interested in whether the problem has persisted steadily or had a more fluctuating course. While a time line for the problem is important, it is the way in which it impacts on present-day functioning that is most relevant for a cognitive behavioural interview.

To elicit the information required to connect the problem with an individual’s core beliefs and assumptions, the focus of the discussion would be on the fine detail of how and when the problem occurs and what impact it has on a service user. Self-monitoring is an integral aspect of cognitive behavioural assessments, using charts such as an A-B-C chart – Antecedents, Behaviours and Beliefs, and Consequences (O’Leary & Wilson, 1975). These are useful in mapping what preceded a stressful event and what was the outcome. This has been developed to include the cognitive
aspects of a situation (Hawton et al., 1995). The example below is how a chart can be used to map mood, precipitating behaviour and behavioural outcomes.

<table>
<thead>
<tr>
<th>Date</th>
<th>Mood and how strong thoughts before event</th>
<th>Activity/ behaviour</th>
<th>Urge to harm self before cutting</th>
<th>Cutting occurred</th>
<th>Relief from cutting</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Feb.</td>
<td>Angry 80%</td>
<td>Arguing with partner</td>
<td>40%</td>
<td>Yes</td>
<td>20%</td>
</tr>
<tr>
<td>8 Feb.</td>
<td>Worried 60%</td>
<td>Daughter large home</td>
<td>60%</td>
<td>Yes</td>
<td>35%</td>
</tr>
<tr>
<td>12 Feb.</td>
<td>Angry 45%</td>
<td>Arguing with son</td>
<td>20%</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>14 Feb.</td>
<td>Upset 70%</td>
<td>Partner forget Valentine</td>
<td>30%</td>
<td>Yes</td>
<td>5%</td>
</tr>
</tbody>
</table>

Greater detail of the problem, i.e. self-harming through cutting in this instance, was achieved through charting the events and outcomes. This does rely, however, on service users engaging with the model and being able to read, write and use numerical skills. It can equally be used to map the occurrence of other mood and behavioural problems, including offending behaviours, unhelpful parenting strategies and behavioural outcomes of low mood.

Defining the details of what triggers and maintains unhelpful behaviours or mood states is undertaken in a cognitive behavioural assessment by six areas of exploration:

1. Situational – what environmental factors were present
2. Behavioural – what did the person do
3. Cognitive – what thoughts were present at the time
4. Affective – what emotional reaction occurred, i.e. overall mood
5. Interpersonal – who else was present
6. Physiological – what bodily reaction resulted

Other significant factors can be gaining insight into a person’s beliefs about a problem as well as taking into account psychosocial factors that would be part of a broader social work assessment.

Using the cognitive behavioural assessment, Gillian extended her understanding of the incident when Aaron physically injured his son. This provided her with a greater insight into the risk factors that would indicate whether it was likely to occur again and also gave Aaron insight into contributing factors in order that he could make changes.

Gillian asked Aaron to track his thoughts, feelings and behaviour over a week-long period.

(Continued)
From this Gillian and Aaron ascertained that Aaron could control his anger, as was evident from his feelings leading to a different behavioural outcome in the Jobcentre. The influence of a different situation, i.e. with other non-family members around, changed the automatic thoughts that Aaron had when feelings of anger arose. This awareness allowed him to recognise his ability for self-control and for exploring his core beliefs that led to the shift in automatic thoughts. Aaron also gained insight into the general level of dissatisfaction that losing his temper gave him. Losing his temper meant that in general he would raise his voice and at times he would break household items. He was surprised to find that, after losing his temper, he would feel an exaggerated sense of worthlessness that exacerbated his problems. This feeling was absent when he returned from the Jobcentre.

Aaron also realised that the people in his life that he valued the most, i.e. his family, were the ones with whom he would lose his temper. Non-family members appeared to have a modulating effect on his mood and behaviour. When exploring this further, Aaron realised that his core beliefs led him to expect his family to remain with him unconditionally out of duty, where he had a greater fear of rejection and reprisals from others. Only when Aaron had had to leave the family home during the child protection investigation had he realised that his relationships with his family were not as certain as he had once thought.

**Social Work Application**

A cognitive behavioural assessment considers only the factors present when an individual has an unhelpful emotional or behavioural outcome to an event on a basis regular enough to be impairing social functioning. What this assessment lacks from a social work perspective is a broader exploration of the social and relationship factors that could also be maintaining an emotional or behavioural response. The assumption with this model is that some form of
cognitive distortion exists, outlined above. However, we need to be mindful that experiences of poverty, oppression in various forms and social and emotional deprivation can also generate problems with anxiety and low mood. Unresolved traumatic experiences can create anxiety problems that do not always fit with a person's current circumstances and could be overlooked if this approach is adhered to without some degree of openness to other influencing factors.

This form of assessment would mostly best fit with social work practice after wider social factors have been given attention. Trying to resolve problems through therapeutic intervention when environmental triggers remain for an individual might only deny experience rather than resolve its impact. This assessment appears to be most useful in social work practice as part of an assessment and intervention process that has identified a service user having unhelpful thought patterns that impairs their social functioning, alongside an assessment of contributing social factors.

Skills Component

- Firstly, use problem identification as part of a broader social work assessment to highlight problems of mood or behaviour
- Draw upon a cognitive behavioural assessment to give greater depth to the manner in which unhelpful thoughts and behaviours interfere with social functioning and relationships
- Explore the six key areas of an event to give a level of depth as to triggers, thoughts, feelings and impact on self (service user) and others

Socratic Dialogue

Therapeutic conversations from a cognitive perspective are based upon the Socratic method. This method has three fundamental features: systematic questioning, inductive reasoning and constructing universal definitions. Systematic questioning requires the practitioner to be curious about several key features of the problem and be open as to what the answers to these questions might be.

Rutter and Friedberg (1999) outline a five-part process to developing a Socratic dialogue:

1. Elicit and identify the automatic thought
2. Tie the automatic thought to the feeling and the behaviour
3. Link the thought–feeling–behaviour sequence together with an emphatic response
4. Obtain collaboration on steps 1–3 and agreement to go forward
5. Socratically test the belief

This form of dialogue to be undertaken with a service user takes the theoretical concepts above and brings them into direct practice. The problem identification step needs to be undertaken before attempts are made to link a person’s core assumptions with their thoughts, feelings and behaviour. Without engaging the service user in this form of intervention prior to this stage, successful collaboration with service users is unlikely.

To elicit and identify automatic thoughts, direct questioning, such as ‘what went through your mind then’ can be useful if timed with a service user’s description of a problematic event. The service user then has the opportunity to track and share automatic thoughts that occurred alongside an unhelpful emotional or behavioural reaction.

Guided questions to broaden the service user’s description of a situation where the problem occurred can also assist in this process. For example, when discussing extreme anxiety at traffic lights with the woman referred to above (whose fears are triggered by her interpretation of the chaotic and dangerous nature of these junctions and the belief that she has that she as passenger and the driver will die if they go through them), we might ask certain guided questions to test the evidence of these core assumptions. We could enquire whether there were other road users at the lights, whether the other drivers were adhering to road safety laws, whether her companion adhered to the road traffic laws at the lights etc. Thus automatic thoughts can begin to be challenged by evidence recognised by the service user that her automatic thoughts are based on distorted cognitions, not what was evident in the situation. Alternative explanations, i.e. regarding the level of safety for car passengers at traffic lights, can be sought in the light of the new evidence. Automatic thoughts can thus be challenged in a non-critical and collaborative manner. Examining and evaluating the evidence to support or challenge automatic thoughts, is called distancing from the problem and adopting a more realistic position.

The final component to the Socratic dialogue is to construct universal definitions. Often people with emotional and behavioural problems define themselves and their world in narrow terms based upon negative and unhelpful beliefs and assumptions. These narrow definitions restrict a person’s ability to view their more positive attributes and aspects of the world around them that could give them joy and pleasure. Using this technique would be to assist a service user to broaden their definition of themselves and their world through challenging cognitions and using activity schedules to alter behaviour.

During their work together, Gillian used Socratic dialogue to track some of Aaron’s automatic thoughts. This allowed Aaron to extend his awareness of his thoughts, feelings and behaviour and gave him a greater sense of self-control. She did this by carefully listening to how Aaron described himself and his world, noticing themes that indicated general negative assumptions that did not always seem to fit with those of others around him, including his family.
(Continued)

Asking Aaron what went through his mind at trigger points to certain events made his automatic thoughts more explicit. She then considered with Aaron some of the assumptions he had made explicit about his world and his relationships to explore with him whether the evidence that feedback from others gave really did fit with his assumptions. Using distancing, Aaron and Gillian were able to gradually formulate a broader definition of who he was and what his world was like. This created therapeutic space for more positive attributes to be included alongside the negative ones.

As Aaron began to recognise more of his strengths, he became more assertively able to share his thoughts and opinions. This in turn left him feeling more in control of his life and his feelings of anger lessened.

Social Work Application

As social work practitioners, the Socratic dialogue offers us a framework for forming the content and sequence of questions that can be used to illuminate a service user’s unhelpful automatic thoughts. The dialogue in itself is not enough for skilled communication. We still need to give emphasis to the ongoing maintenance of the therapeutic relationship by being consistent, respectful and reliable. We need to draw upon listening skills to ensure that we are attentive to the service user and the service user’s feelings. As mentioned previously, without consent to question people about their automatic thoughts and the core beliefs upon which these are based, this technique could be viewed as threatening and intrusive. If a service user perceives our intervention in this way, unless stipulated by statutory requirements, he or she is likely to withdraw engagement with us or with the work, either overtly by avoiding meeting with us or more subtly through an emotional withdrawal.

Skills Component

- Become familiar with the Socratic dialogue as a framework for forming questions
- Use it in conjunction with skills to promote a working relationship, i.e. respect, reliability and consistency
- Incorporate the dialogue into other forms of communication to retain focus on engagement, i.e. listening skills and attentiveness
- Re-visit the service user’s consent to the work to avoid withdrawal from perceived over-intrusiveness


Other Cognitive Behavioural Techniques

Reattribution

Reattribution concerns assisting service users to reattribute negative outcomes of events or experience away from perceived internal and self-critical causation to external influence. Reattribution is not intended to move people to avoid taking responsibility for their lives and their actions. Rather, it works to facilitate an individual to move away from unhelpful negative emotions that debilitate self-control and self-action when faced with unsatisfactory outcomes.

Aaron had become self-blaming for many of the negative experiences he had had, including being out of work for many years. He viewed his long period of unemployment as a reflection of his lack of skill and his unattractiveness to potential employees as somehow unworthy of finding a job. He had internalised the problems which in consequence led him to view his future prospects as extremely bleak.

Gillian assisted Aaron to consider the local employment situation and to make sense of the lack of industry in his area that led to a decline in the opportunities for someone with his trade. They also explored with employment agencies the kind of attributes and experience that were sought to secure alternative employment. Aaron realised that he had some of those attributes and took steps to re-train in a different skill. As he began to reattribute some of the barriers to finding work to societal factors, he felt more optimistic about the future and was empowered to take active steps towards changing his future.

Social Work Application

Our social work values require that we assist people wherever possible to take more control of their lives. In doing this, we are thinking about matters relating to various forms of oppression, deprivation and social exclusion that prevent people fully participating as members of their local communities. Furthermore, we assist people to take responsibility for their actions and to consider alternative paths that are either less harmful to others or have less impact on the safety and well-being of the local community. When this includes offending behaviour or forms of abuse, reattribution techniques would not be helpful.

However, as we can see with the work undertaken by Aaron and Gillian, some of the unhelpful beliefs about the world and of the opinions of others that contributed to Aaron physically assaulting his child were reattributed to socio-economic factors, not his responsibility for the assault itself. This allowed
Aaron to have a broader view of his own positive attributes that he was previously ignoring or filtering out of his perception.

While reattribution techniques do not always fit with social work practice, especially when a service user is struggling to accept responsibility for behaviours that have been harmful to others, it does offer the distinction between responsibility and blame. Aaron needed to accept responsibility for the assault and the consequences that followed but was not wholly to blame for the social circumstances of his early history and his present situation. Using this technique does allow the distinction to be made between responsibility for individual behaviour and blame for the socio-economic circumstances that can be restrictive and oppressive.

Skills Component

- Distinguish between behaviours for which the law requires that an individual takes responsibility and societal factors for which an individual does not accept personal blame
- Assist service users to take responsibility for their own thoughts, feelings and behaviours
- Assist service users to reattribute blame for the generation and shaping of beliefs and assumptions over time as a result of situational factors, i.e. societal, economic, political, religious and from early negative experiences of relationships
- Use the reattribution process to free individuals to change their core beliefs and assumptions that can result in different automatic thoughts, feelings and behaviours

Challenging General Rules

General rules are the beliefs and theories that emerge from the cognitive schemata in raw or abstract form, that then influence the perception of experience or likely future experience. These general rules are the basic blueprint for how we experience and anticipate life: for example, ‘people are untrustworthy’; ‘life lets you down’; ‘things are too good to last’. With vulnerable people whose life experience has been difficult or traumatic, we often find that this blueprint, or the general rules applied to life as a whole, is largely negative. As these general rules continue to be applied to life, exceptions can be missed that challenge them. The times when a friend remains loyal and trustworthy, or when a good experience has not ‘gone wrong’ are not acknowledged and so the general rules remain unchallenged.
Counselling Skills for Social Work

Cognitive behavioural models can assist us to challenge negative ‘general rules’ through distancing from a problem enough to consider evidence that either supports or negates basic beliefs, using the Socratic technique, detailed above, to weigh up advantages and disadvantages for maintaining the belief.

Blackburn and Davidson (1995) outline some techniques for ‘extracting’ or making sense of ‘general rules’ useful for social work practice. These include using specific examples given by the service user and tracking ‘common themes’. Rules that are then applied by service users for their personal lives can be traced by the times statements are made about what they ‘should’ be doing. The worker and the service user can explore the implications of these rules and how they have developed to form automatic thoughts, by applying the technique detailed in the example below.

The aim of these techniques is not to create a crisis for an individual, whereby all sense of understanding of the world is challenged. Instead, the primary objective is to gently assist individuals to make their own gradual shifts in their belief system and thus their automatic thoughts, to incorporate more flexibility in their perception of events.

In discussing family relationships, Aaron had described how ‘everyone’ in the family, including his partner, ‘always’ ignored him whenever he had something to say. Gillian used this technique to challenge this rule that he applied to himself and his family.

Gillian asked Aaron to give her a specific example of when he thought he was being ignored. Aaron described an evening when his partner had returned from her new job and had excitedly told him all about her day but ignored his experience of being frustrated and lonely that day. Gillian asked Aaron what had been so upsetting to him that his partner had been speaking about her new job when she came in and not asking about him? Aaron described how he thought this meant that she had not thought of him all day and that she valued him very little. Gillian then asked him, ‘Suppose she had not thought of you all day, what would this mean to you?’ Aaron replied that it would mean he was worthless. Again Gillian followed his train of thought and asked him, ‘Suppose you were worthless, what would this mean to you?’ Aaron responded that it would mean no one would like him or take the time to get to know him. Gillian replied, ‘Supposing this was true, what would that mean to you?’ Aaron described how he would be forever lonely with no friends or family that would make time for him. He added that he thought it would mean that he was unlovable and that life would not be worth living.

Gillian stopped this by summarising, ‘Does this suggest that you believe that unless people do not talk about their own experiences, that you are worthless and that your life is not worth living?’ Aaron corrected Gillian by stating that he thought it was okay for people to talk to him about their own experiences sometimes and that he liked the idea of being a good listener. Aaron, through participating in this exercise, had challenged his own beliefs about what had happened that day. He began to change his perception of his partner’s excitement regarding her first day at her new job and how she had wanted to share it with him because he was important to her, rather than because he was not.
Social Work Application

Many service users that become known to social workers have had many negative experiences or have been subject to oppressive societal forces that leave people marginalised and disempowered. In these circumstances, it is likely that most people would attribute some general rules that are negative and unhelpful and do not fit with other people's accounts. Unhelpful general rules can interfere with service user engagement with services and with their motivation for change. These general rules that tend to be wholly applied to life and experience can seriously inhibit an individual's participation in society and in meaningful relationships. In turn, these patterns of thought can lead to chronic problems of worrying about the future and of low mood.

Using this technique to challenge general rules could be perceived to be dangerous in that we would be following an individual's train of thought and taking it to an extreme position. To effectively use the technique, we need to develop a confidence based on judgement that we are not pushing an individual to perceive our questions as feedback that they really are 'unlovable and unworthy'. Using this technique with someone who has suicidal thoughts would not be recommended. Rather, an individual requires some degree of resilience in order to challenge the extreme position as not fitting with their own feelings, beliefs and desires. As with all therapeutic techniques, there is an inherent risk that intrusive and challenging questioning could shake the fragility of vulnerable people's cognitive and affective structures that allow them to survive in difficult circumstances. Before we embark on this or any other technique, we need to be as certain as we can be that a degree of safety is experienced by an individual within their own living environment to allow them to explore unknown or possibly dangerous cognitive and affective territory.

Skills Component

- Use judgement to evaluate whether a person's vulnerability and resilience would allow them to tolerate exploring an extreme position of general rules enough to challenge it
- Use caution to avoid this technique if not certain of its suitability for an individual
- Use this technique only after an assessment of the environmental and situational factors to ensure a high enough level of safety for an individual – emotional and physical
- Consider evidence given in discussions with the service user that indicates that an extreme position is unlikely to fit with their beliefs and desires
- If in doubt with this fit or a person has suicidal thoughts, avoid this technique
Desensitisation

This technique is primarily used to assist people to confront and change avoidance behaviour due to highly anxious responses to specific situational triggers. This thought/behaviour pattern is often termed a phobia. Hawton and colleagues (1995) provide a model to explain how phobias become a ‘vicious circle’.

This model helps us connect the link between thought processes, i.e. the subjective cognitions based on basic beliefs held in the schemata, with behaviours that reinforce beliefs, as they are not challenged. To challenge the beliefs about a phobic reaction, a degree of tolerance of anxious feelings is required. An individual needs to tolerate uncomfortable anxious feelings enough to progress with a desensitisation programme. Thus the first step needs to be an educative role to assist an individual to understand how phobias are being maintained.

Desensitisation techniques are not outlined in detail in this chapter. However, the function of a desensitisation programme is to gradually assist a person to build up...
exposure to a situational stressor and learn to tolerate anxious feelings in the process. As the programme progresses with ‘graded hierarchies’ of the problematic situation, a service user begins to challenge beliefs about a stressor and about the causation of automatic thoughts that lead to physiological and psychological distress.

Anthony is a 10-year-old boy who had a generally anxious pattern of seeing his world. He had always been a quiet boy with no observed problems at either home or school. However, his family moved from a rural area to a large town in October. During this time, Anthony and his family had noticed a significant increase in the amount of fireworks that would be set off compared to his previous community. He had always had a fear of fireworks and thunder and had managed to avoid them by staying in the house at times of thundery weather or firework displays. In his new community, the period of time for fireworks to be set off had greatly extended. Anthony managed his anxieties by refusing to leave the house, even for school. Anthony came to the attention of a social worker following several months of school refusal. Anthony worked with his social worker, Mrs Asghar, to develop a graded hierarchy of situations that he feared and worked with her to learn to tolerate his anxious feelings through gradual desensitisation. Through her work with Anthony and his family, Mrs Asghar noticed that Anthony’s mother would also become very anxious when he became upset and would assist him to avoid certain situations to protect him from his feelings. Mrs Asghar worked with his mother also to assist her to tolerate her own feelings of anxiety to allow Anthony to make progress with the programme.

Social Work Application

‘Simple’ phobias without the complexity of other social and relational factors are unusual in social work practice. More usual is the development of a phobic form of anxiety as part of a host of other difficulties which mostly require intervention firstly. For example, an older woman developing a fear of mixing with others after her partner dies might on the surface appear to have a phobia of leaving the house. However, the woman might be struggling with unresolved losses complicated by her recent bereavement. She might have physical impairments that leave her feeling more vulnerable. She might have relied on her partner to assist her to go out, either for physical or emotional support. Many other examples might be offered to indicate how the avoidance of objects, people or places might not be directly related to phobias.

However, once other contributory factors have either been ruled out or addressed, desensitisation programmes can be useful tools for social workers to incorporate as part of intervention.

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Skills Component

- Take into account other possible explanations for behaviours and fears
- Address other contributing factors first
- Introduce a desensitisation programme by exploring and formulating a 'graded hierarchy' of the severity of fear in given situations
- Assist a service user to tolerate their feelings of anxiety by starting with exposure to the least fearful trigger
- Introduce relaxation techniques (below) to enable a service user to tolerate their anxiety

Summary of Key Cognitive Behavioural Concepts

- Development of beliefs through experience from infancy and consolidated during adolescence becomes established as Cognitive Schemata
- **Automatic Thoughts** occur in response to anticipated events based on assumptions derived from beliefs held within the Schema
- Perceptions are filtered by the Schema so that we emphasise experience that fits with our beliefs and expectations and dismiss others, leading to **Cognitive Distortion**
- Experiences that generate unhelpful assumptions leading to cognitive, emotional, physiological and behavioural consequences are termed **Critical Incidents**
- **Content-specificity Hypotheses** group together patterns of unhelpful thoughts that lead to anxiety problems and generalised low mood
- The **Therapeutic Relationship** is the necessary context for cognitive behavioural approaches
- Practitioners use **Socratic Dialogue** to track and challenge unhelpful automatic thoughts
- **Reattribution** is used to assist service users to reattribute negative outcomes of events or experience away from perceived self-critical causation to external influence when persistent negative thoughts impair self-control
- Practitioners challenge **General Rules** that are applied to life when views of the world have become narrow and inflexible to the extent that positive events are dismissed
- **Desensitisation** is the technique used to gradually expose a person to anxiety-provoking stimuli in a staged way to address phobias
Conclusion

In social work practice, we regularly meet individuals whose lives are affected by low mood or by anxieties. With our knowledge of societal influences that stigmatise certain groups of people, marginalise others through poverty and deprivation, and oppress people through racism and homophobia among other forms of prejudice and discrimination, we can make sense of some of the reasons why some people might experience low mood and anxieties. Cognitive and behavioural theories do acknowledge the impact of culture and society upon thought processes and behavioural responses, although the focus for change is targeted at individuals rather than the environment.

In social work practice, we can judiciously use these techniques in conjunction with considering societal and environmental factors that can contribute to problems. As social workers, our role is to be mindful of the interconnection between environmental, social and political aspects of life with internal processing of information. When this interconnection is in equilibrium, i.e. the environmental stressors are not overwhelming internal coping mechanisms, an individual can function adequately in the social world. However, when either the coping mechanisms (or core beliefs that shape perceptions) become overwhelmed or the environmental stressors become too high, an individual’s social functioning can be compromised. We can integrate cognitive behavioural approaches into our practice while ever we also remain aware of the need to address socio-environmental problems.

With therapeutic techniques comes an inherent danger that social functioning can be improved by ‘counselling’ or ‘therapy’ alone. The social model upon which we base the foundation of our practice allows us to avoid this trap by taking into account the environmental elements to thoughts, feelings and behaviours before we focus on internal mechanisms.

Further Reading

- Wills and Sanders (2002) offer a concise and ‘easy to read’ overview of this approach that could be further applied to social work practice. Their use of diagrams to explain key principles and their emphasis upon the therapeutic or collaborative relationship lends itself especially towards compatibility with fundamental social work values.

- Friedberg and McClure (2002) also offer a clear overview of the theoretical principles linked with this approach but tailor it specifically to the needs of children and young people.

- Blackburn and Davidson (1995) offer a book more specifically directed towards practice with adults with problems with low mood or anxiety.