

# CBT *FOR* BEGINNERS

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# PART ONE

## CBT – WHAT IS IT?



# What is CBT?

What is cognitive behavioural therapy (CBT)? CBT is currently a much ‘bandied about’ term, especially as it is used liberally in the National Institute for Health and Care Excellence (NICE) guidelines ([www.nice.org.uk](http://www.nice.org.uk)) and recommended for use with most common mental health problems. It is often described as a guide to thinking positively, which is somewhat misleading. Curwen et al. (2000) provide a comprehensive list of the characteristics of CBT as follows:

- therapeutic style
- psychological formulation of the problem
- collaborative relationship
- structure to sessions and to therapy
- goal-directed therapy
- examination and questioning of unhelpful thinking
- use of a range of aids and techniques
- teaching of the client to become their own therapist
- use of homework or assignments
- time-limitedness
- audio-recording sessions.

## Therapeutic style

The therapeutic style of CBT is different from some other forms of therapy. It assumes that clinicians bring with them a range of skills and ideas about intervening. It is more than just active listening. The clinician is active and works with the client to elicit information relevant to the client’s difficulties.

## Psychological formulation of the problem

Briefly, a psychological formulation is a ‘picture’ of why someone is experiencing the problems they are. It differs from diagnosis in that it provides an explanation, rather than a label. Psychological formulation is covered in detail in Chapter 8.



## Collaborative relationship

The client and therapist work together to build up the formulation, with the therapist using a questioning process to develop a picture of the difficulties with the client. CBT is very transparent and each stage of formulation building is shared with the client. It is as though the client and therapist are going on a voyage of discovery, with the therapist asking curious questions and building hypotheses based on the difficulties being experienced.

## Structure to sessions and to therapy

CBT therapists tend to make an agenda at the beginning of each session – this is negotiated with the client and helps to make use of limited time and to give the sessions a ‘problem-solving’ atmosphere. Sessions tend to be offered in a series of blocks followed by a review, which gives the client the opportunity to give feedback formally or to opt out of therapy. It is always assumed that therapy will come to an end at some point, which can aid clients with dependency issues. The structure of therapy and sessions is discussed in detail in Chapter 5.

## Goal-directed therapy

The client and therapist work collaboratively to develop goals – these may change over time and at reviews. The goals are most useful if they are quite specific. For example, a client may say ‘I want to go out more,’ but this does not give them anything concrete to work on, and so goals need to be more defined. ‘I want to go out more’ becomes ‘I want to go to the local shop.’ Goal setting is discussed in Chapter 9.

## Examination and questioning of unhelpful thinking

The main foundation of CBT is examination and questioning of unhelpful thinking, and it is what everyone tends to think of when CBT is mentioned. The CBT approach uses a series of questions to enable clients to examine their thought processes and assess whether their approach is most helpful to them. Several chapters in the book cover this topic as it is laced through CBT from assessment to formulation to intervention.

## Use of a range of aids and techniques

The course of therapy is directed by the formulation, which can be developed over time. This includes the use of a range of techniques, which are described in the



intervention chapters. Questionnaires may also be used to evaluate the changes that clients make during the course of therapy, and this is discussed in Chapter 7 on assessment.

## Teaching the client to become their own therapist

Hopefully, the client will be able to see their own part in overcoming their difficulties throughout the therapy process. Some clients find this easier than others. Tasks between sessions can help the client to feel that they are working on their difficulties themselves. It can be important to remind the client regularly that they are in control of the changes they make, and also that the time spent in sessions with the therapist usually accounts for either an hour a week or an hour fortnightly. Not very much! Relapse prevention and the ‘end of therapy letter’ are discussed in Chapter 20 on endings. These are both very useful tools towards the end of therapy.

## Use of ‘homework’ or assignments

‘Homework’ essentially refers to tasks that the client conducts between sessions. It is important for the client to be able to do work between sessions, especially as the time in therapy sessions is limited to an hour every one or two weeks. It helps with the continuity of making changes and gives clients the feeling that it is they who are doing the work, rather than a therapist with a magic wand. An example of a piece of ‘homework’ is to complete a thought record (see Chapter 13) or to walk to the end of the garden once a day. There can be difficulties with the term ‘homework’ as it can conjure up images of school – not always the happiest time for many people; other terms can be ‘assignment’ or ‘between-session tasks’.

## Time-limitedness

CBT is time-limited, which means that the therapy always has an ending in sight. The goal of the therapy is to teach clients to become their own therapist, rather than becoming dependent on therapy. Regular reviews help to keep this goal in mind.

## Formal and informal CBT

CBT can be practiced formally, as described in this book. However, CBT can also be used in a more informal manner, using some of the techniques (e.g. drawing out a thought cycle or using thought challenging) without offering a full package of CBT.

## Audio-recording sessions

Audio-recording of sessions is often used in CBT, especially during training of therapists. It can also be helpful for clients to listen back over sessions. However, this method is not used by all therapists.



## Limitations/criticisms of CBT

Gaudiano (2008) notes that there are some criticisms of traditional CBT, citing the arguments of a number of critics that CBT is too 'mechanistic' and only focuses on one or two aspects of a person and their difficulties. Additionally, he observes that research indicates that specific behavioural techniques are as effective as CBT in treating depression. Later research by Richards et al. (2016) mirrors this finding and suggests that behavioural activation is at least as effective as CBT in treating depression and can be delivered at less cost by more junior mental health staff. Gaudiano also discusses the lack of connection between the theoretical basis of CBT and the science of human cognition which has led to a need to adjust some of the central concepts of CBT over time so that the two strands of knowledge match up.

## History and empirical basis of CBT

As well as having the above characteristics, CBT is a therapy that has developed through rigorous research and outcome studies. Behavioural therapy was the first to emerge, based on principles of animal learning and the work of Pavlov in the 1890s and 1900s (Pavlov 1927), as well as research on human anxiety by Watson and Rayner in 1920. Behavioural approaches subsequently became popular for work on problems such as anxiety, and research was being conducted routinely (e.g. Shapiro 1961a, 1961b).

This early research and exploration helped scientists to recognise two principles of animal learning: classical conditioning and operant conditioning. The work of Pavlov helped to identify the phenomenon known as 'classical conditioning'. The experiments were first conducted with dogs, where food was given to the dogs directly after a bell was rung. This was then replicated until the dogs began to salivate when the bell was rung, without needing the food to appear. This is known as classical conditioning. In this particular experimental set-up, the food is known as the 'unconditioned stimulus' because it produces salivation before learning (conditioning) has taken place. The salivation caused by the food is known as an 'unconditioned response'. Once the bell had been paired with the food a number of times, the bell caused the salivation to occur without needing the food to be present and is thus known as the 'conditioned stimulus'. The salivation produced by the sound of the bell alone is known as the 'conditioned response'. Pavlov continued his experiments and noted that if the bell continued to be rung without food appearing afterwards, the 'conditioned response' gradually 'extinguished'. Other researchers have shown that emotional responses such as fear and anxiety can be conditioned.

The second principle recognised by scientists was 'operant conditioning' and experiments conducted by Thorndike, Tolman and Guthrie showed that if a reward habitually followed a certain behaviour, the behaviour would be more likely to recur. This principle was elaborated on by Skinner, who identified reinforcers in terms of the effect that they had on a person's behaviour. 'Positive





reinforcement' is said to occur when positive consequences lead to a behaviour occurring more frequently. 'Negative reinforcement' is where the frequency of a behaviour increases because a predicted feared consequence does not occur. 'Punishment' is where an aversive event following a behaviour leads to a decrease in that behaviour.

These two conditioning phenomena were vital in terms of the development of behaviour therapy. One of the most well-known examples where behavioural principles were used to elicit clinical anxiety was Watson and Rayner's (1920) experiment with 'Little Albert', an 11-month-old baby boy. They paired the appearance of a white rat with a loud noise, which led to a conditioned anxiety response in the little boy. Albert developed a fear of rats as well as things resembling rats, such as white beards and white dogs. There seems to be some debate over whether Albert's conditioned fear was actually ever extinguished. This type of experiment would not actually be allowed in accordance with the ethical standards of today and would be considered unethical by the ethic's code of the American Psychological Association. This is because Albert was not protected from psychological harm, and a number of sources state that the permission of his mother for his inclusion in the study was not obtained.

In terms of treatment approaches, work was being done in the 1960s at the Maudsley and Warneford Hospitals to develop exposure therapies to treat phobias. In exposure therapies, patients are exposed to feared stimuli until their anxiety declines. This is based on the principle that anxiety will decline if a person stays long enough in a situation and nothing aversive happens. People tend to avoid stimuli that cause anxiety, so exposure therapy aims to reverse this process. In systematic desensitisation, this exposure happens on a gradual stepwise basis, with the patient being exposed to the feared stimuli in a systematic way until their anxiety declines.

The operant approach did not really start to be applied to clinical problems until the 1960s. Early treatment approaches focused on changing behaviours such as violent acts in psychotic patients using reinforcers such as cigarettes and praise. This evolved further through the work of Ayllon and Azrin (1968) and became known as 'token economy' due to the use of tokens as reinforcers in hospital psychiatric wards. These tokens could then be traded in for a range of privileges that the patients could choose from.

However, it was not until the 1970s that behavioural therapy really came to the fore. It was now being routinely used to work on problems such as anxiety, although some noted that it did not work for every person or problem. Foa and Emmelkamp (1983) wrote a book on treatment failures, which served to highlight some of the gaps in a solely behavioural approach. Purely behavioural approaches were starting to become less popular and cognitive approaches were becoming more interesting to behavioural therapists. The approaches of Aaron T. Beck and Albert Ellis were starting to be taken seriously. Ellis had developed rational emotive therapy (REBT) in 1955. It was originally called 'rational therapy' and is both a psychotherapeutic system of theory and practices and is also a school of thought founded by Ellis. Other behavioural researchers also



started to get interested in a cognitive approach, and ‘self-instructional training’ (Meichenbaum 1975) became popular at this time. Briefly, ‘self-instructional training’ worked on the premise that behaviour change could be elicited by helping patients to become more aware of their self-talk and by changing the instructions they gave themselves, away from unhelpful, upsetting thoughts and towards more helpful self-talk. Traditional cognitive therapy as described by Beck (1970, 1976) gradually began to be adopted on a wide scale and has been extremely influential in the development of CBT, an integration of cognitive and behavioural approaches. To begin with, Beck’s methods were applied mainly to depression (1967). Beck hypothesised that the negative thinking so widespread in depression is not just a symptom but also plays an important function in the maintenance of depression. This then led to the assumption that identifying and modifying negative thoughts would help clients to recover from their depression.

As CBT has become more widespread, it has been subjected to rigorous outcome research and has been shown to be a valuable approach with a considerable range of psychological problems (Roth and Fonagy 1996). However, Dudley and Kuyken (2006) note that one of the key aspects of CBT – the concept of ‘formulation’ (see Chapter 8) – has yet to be fully researched, although pertinent research is beginning to materialise (see Kuyken 2005).

## Recent developments in CBT

CBT, as described above and throughout this book, is along the lines of the more traditional approach to CBT. However, CBT is continuing to develop and evolve and this section highlights some of these developments. Reasons for moving beyond the traditional framework of CBT might include situations where the standard approach does not seem to be evoking change but where the client’s difficulties seem to suggest that a CBT formulation and intervention which includes some of the new approaches might be appropriate. Additionally, recent research suggests that certain presentations work well with some of the new methods. For example, mindfulness-based cognitive therapy (MBCT), which is described below, has been found to work well with people experiencing recurrent depression (Piet and Hougaard 2011). Dialectical behaviour therapy (DBT) (Linehan 1993), which is a skills-based approach containing a high percentage of CBT concepts, has been found to be effective with clients with a diagnosis of borderline personality disorder (Bohus et al. 2004) and is generally effective in terms of helping clients to reduce dangerous behaviours. Other therapies which share some similarities with CBT and have been found to be effective are described in more depth below. These are: acceptance and commitment therapy (ACT) (Hayes et al. 2001), which has been shown to be effective with a range of different presentations (Powers et al. 2009); and compassion-based therapy (Gilbert 2005), which has been shown to be particularly useful with clients who experience high levels of shame and self-criticism (Gilbert and Procter 2006). We will now describe some of these approaches in more detail.



## Mindfulness-based cognitive therapy (MBCT)

MBCT was developed by Segal et al. (2002) and had the aim of helping clients who experienced repeated episodes of clinical depression. It was therefore mainly used as a relapse-prevention approach initially. MBCT is based on the mindfulness-based stress reduction (MBSR) eight-week programme developed by Jon Kabat-Zinn in 1990, and essentially brings together standard CBT approaches with mindfulness. In brief, mindfulness means paying attention in a particular way: *in the moment and non-judgementally*. See Chapter 16 for a full description of mindfulness and how it can be used in therapy settings. MBCT proposes to enable clients to become aware of unhelpful thoughts and images, to label them and distance themselves from these thoughts and images, moving back to being in the moment.

Piet and Hougaard (2011) conducted a systematic review of data from six randomised controlled trials, which indicated that MBCT is associated with a 43 per cent reduction in depressive relapse risk when evaluated next to usual care for clients with at least three previous depressive episodes. MBCT is now recommended in the National Institute for Health and Care Excellence depression guidelines (NICE 2017) as the treatment of choice for those who are currently well but have experienced at least three depressive episodes.

## Acceptance and commitment therapy (ACT)

ACT (Hayes et al. 2001) derives its name from one of its central messages: accept what is out of your personal control and commit to action which improves and enriches your life. The main goal behind ACT is to help clients to develop a full and meaningful life. ACT uses some core techniques to enable change: mindfulness including defusion techniques, acceptance and commitment to values-based living. (For more on mindfulness, see Chapter 16.) In terms of acceptance, ACT centres on the idea that distress or pain is actually increased when we try and focus on getting rid of it. Therefore, another option is to accept it. This does not mean being defeated by it; rather, it means allowing difficult or painful feelings to be present, creating room for them without struggling against them. The values aspect of the therapy involves the client learning what is truly important to them and committed action then involves setting some goals according to these values. ACT has been shown to be effective with a number of different presentations (Powers et al. 2009; Zettle et al. 2011).

## Compassion-based therapy

Compassion-based therapy (Gilbert 2005) draws from a number of different approaches, such as social, developmental, evolutionary, neuroscience and Buddhist psychology. One of its main concepts is the use of compassionate mind training to



help people to develop and expand on experiences of inner warmth, safety and self-soothing. Compassion-based therapy is particularly targeted at people who experience shame and self-criticism as these are people who may struggle to feel relieved, reassured or safe. The main aim is to enable people to develop self-compassion, and research indicates that learning this skill can be valuable in both student (Leary et al. 2007) and clinical populations (Mayhew and Gilbert 2008).

## Developments in the provision of CBT

Improving Access to Psychological Therapies (IAPT) has come into force since the first edition of this book was written. IAPT was commenced as a result of the economic evaluations of Lord Layard, the idea being that treating anxiety and depression would increase well-being and enable people to return to work. The first national demonstration sites were set up in Doncaster and Newham in 2006, with the aim of testing the effectiveness of providing considerable increases in evidence-based psychological therapy services for people with anxiety and depression. Targets included improving health and well-being and keeping people in work or helping them to get back to work. Although primary care services are being set up throughout the UK and CBT is practised throughout the world in different ways, IAPT, as described, is so far limited to England.

IAPT was introduced throughout England following the set-up of the demonstration sites, using a stepped care approach, with people mostly receiving low-intensity interventions in the first instance and some receiving high-intensity interventions. Low-intensity interventions include guided self-help, computerised CBT, psycho-education groups, behavioural activation and exercise on prescription. This book focuses more on standard CBT which equates to high-intensity interventions. However, we take more of a general approach to formulation, rather than using individual models for each disorder. Despite the more general formulation approach, we do show how an individual's difficulties can be formulated and worked with according to their individual needs.

Initial research indicates that IAPT has resulted in good research outcomes (Richards and Suckling 2009); however, further research is required before firm conclusions can be drawn about this way of delivering services.

### Summary

- CBT is currently a much discussed therapy.
- CBT is recommended by NICE for many common mental health problems.
- CBT has a number of characteristics and has developed through rigorous research and outcome studies.
- CBT is continuing to develop and new ways of delivering CBT are also being explored.



## Further reading

- Curwen, B., Palmer, S. and Ruddell, P. (2000) *Brief Cognitive Behaviour Therapy*. London: SAGE.
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