Michael Neenan and Windy Dryden

Second Edition

COGNITIVE THERAPY
in a nutshell

COUNSELLING IN A NUTSHELL SERIES: Edited by Windy Dryden

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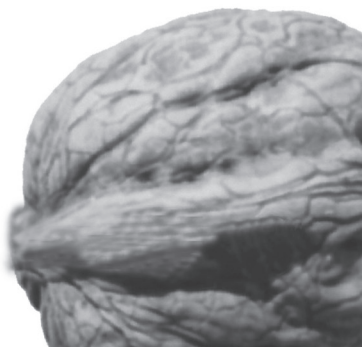

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Preface

There is a vast literature on cognitive therapy (CT) as befits the 'single most important and best validated psychotherapeutic approach. It is the psychological treatment of choice for a wide range of psychological problems' (Salkovskis, 1996: xiii; Hollon and Beck, 2004). However, a newcomer to CT could feel daunted by having so much on offer but not knowing where to start to gain an initial understanding of this approach (plunging straight into disorder-specific treatment manuals could be confusing as these are written for experienced CT practitioners, not beginners). Therefore, our aim in this book is to present the key elements of cognitive therapy, both theory and practice, in as few words as possible. We have used the case example of a client with social phobia in order to demonstrate CT in action. We have endeavoured to make our presentation of CT clear and our prose style easy to read as befits the books in the Counselling in a Nutshell series.

ONE

An Overview of Cognitive Therapy

Introduction

Three people working for the same company at the same level and salary are all made redundant at the same time. The first person is angry because she believes she should have been promoted, not sacked; the second person is anxious because he thinks about the financial difficulties that lie ahead; the third person is hopeful because she thinks about the good opportunities that redundancy may lead to. These three different emotional reactions to the same event underscore a key idea in cognitive therapy (CT): namely, that our reactions to events are powerfully influenced by the way we view these events. By 'tapping the internal communications' (Beck, 1976), you can discover the thoughts and beliefs that largely determine your emotional responses to events. Clients are often surprised to learn that they are, in general, responding to their interpretation of the event rather than the event itself, e.g. 'I always thought that being criticized made me angry but, on reflection, what really triggers the anger is my belief that I've been exposed as stupid and incompetent'. To summarize: the way you think affects the way you feel. As Clark and Beck observe (2010: 31), 'This simple statement is the cornerstone of cognitive theory and therapy of emotional disorders.'

Some clients (and therapists) might say that events do directly cause our emotional reactions and, for example, point to everyone being anxious if they were in a burning building. While everyone may well be anxious, some people might be in a wild panic, creating additional

dangers for themselves and others; some are frozen in terror; while others are struggling to stay in control in order to find a way out. When outside, some will calm down and recover more quickly than others from the ordeal, while one or two individuals may go on to develop full-blown post-traumatic stress disorder (PTSD). All have experienced the same event but only by examining each person's viewpoint can you truly understand why they reacted in the way that they did (and, in some cases, continue to suffer from their experiences). CT teaches clients that there is always more than one way of seeing events and, therefore, their viewpoint is largely a matter of choice (Butler and Hope, 1996).[1] Helping clients to develop and maintain more helpful viewpoints in tackling their problems is the focus of therapy.

CT was developed by Aaron T. Beck at the University of Pennsylvania in the early 1960s. Beck's approach initially focused on research into, and the treatment of, depression (Beck et al., 1979). Since then, CT has been applied to an ever-increasing number of clinical problems such as anxiety and phobias (Beck et al., 1985), substance abuse (Beck et al., 1993), schizophrenia (Kingdon and Turkington, 2004), obsessive-compulsive disorder (Clark, 2004), post-traumatic stress disorder (Taylor, 2006), health anxiety (Taylor and Asmundson, 2004), chronic pain (Winterowd et al., 2003), bipolar disorder (Basco and Rush, 2005), chronic fatigue syndrome (Kinsella, 2007), eating disorders (Fairburn, 2008), and working with couples and families (Dattilio, 2010), groups (Bieling et al., 2006), psychiatric inpatients (Wright

[1] Viktor Frankl, an eminent psychiatrist who survived Auschwitz, wrote:

> We who lived in the concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: the last of the human freedoms – to choose one's attitude in any given set of circumstances, to choose one's way. (1985: 86)

Despite the most appalling and inhuman conditions, a moral life was still possible for some inmates in the Nazi concentration camps and the Soviet gulag system rather than a collective descent into a dog-eat-dog struggle for survival (Todorov, 1999).

et al., 1993), personality disorders (Davidson, 2008), children and young people (Stallard, 2002) and older people (Laidlaw et al., 2003).

CT has a strong commitment to scientific empiricism, i.e. testing its cognitive conceptualizations of various disorders (e.g. panic, health anxiety, obsessive-compulsive disorder) and their accompanying treatment protocols (see Clark, 1996, for the steps to follow in the Beckian approach to psychotherapy research). Scientific empiricism is not only a method but also a mindset – the willingness to abandon key CT tenets if not supported by research evidence: 'This is the gold standard to which we hold an "empirically based psychotherapy": a commitment to empirically examine every tenet of the therapy and follow the data, wherever they may lead' (Padesky and Beck, 2005: 188). Therapists are encouraged to adopt the stance of a scientist-practitioner by drawing on research evidence to inform their clinical practice as well as evaluating the effectiveness of their own practice (see Westbrook et al., 2007); clients are also encouraged to take an empirical stance in testing their problematic thoughts and beliefs and collecting information from experiments in order to develop alternative and more helpful viewpoints. The Beckian view of psychotherapy, which is speaking only from research studies, is challenged by therapists from other orientations who point out that knowledge of human behaviour and change comes from many sources (e.g. philosophy, literature, spiritual traditions) and science is only one of them; a scientific approach cannot answer all questions of importance about the human condition. In our experience, not every cognitive therapist would describe him- or herself as a 'strict Beckian' in the sense of being led only by research.

CT comes under the umbrella term cognitive behavioural therapy (CBT). CBT is not a single approach but made up of various ones such as rational emotive behaviour therapy (REBT; Ellis, 1994), problem-solving training (PST; Nezu et al., 2007), stress inoculation training (SIT; Meichenbaum, 1985), relapse prevention (RP; Marlatt and Donovan, 2005) and dialectical behaviour therapy (DBT; Linehan, 1993). Each approach differs in the varying emphasis it places on cognitive as compared to behavioural principles and interventions (Hollon and Beck,

2004; Craske, 2010). When the same intervention is used, different explanations for change are advanced (Craske, 2010), e.g. in exposure treatment, behaviour theory attributes change to clients' staying long and often enough in feared situations until habituation (anxiety diminishes) occurs while a cognitive perspective attributes change to testing clients' fearful thoughts (e.g. 'I'll go mad if I stay for too long in this shop') in order to provide a direct disconfirmation of them – she did not go mad in the shop – thereby leading to a reduction in anxiety.

Beck's CT is the dominant CBT approach in the UK because of the substantial evidence base supporting its effectiveness and is recommended by the National Institute for Health and Clinical Excellence (NICE) as the first line treatment in the NHS for a wide range of psychological disorders (NICE, 2005). The wider dissemination of CT in the NHS is under way through the government funded Improving Access to Psychological Therapies (IAPT) programme (Department of Health, 2007).

Theory

In this section, we focus on some of Beck and colleagues' conceptual contributions to increasing our understanding of psychopathology (disturbances in thought, feelings and behaviours) and its amelioration.

Information-processing model

The cognitive theory of psychopathology is based on an information-processing model 'which posits that during psychological distress a person's thinking becomes more rigid and distorted, judgements become overgeneralized and absolute, and the person's basic beliefs about the self, [others] and the world become fixed' (Weishaar, 1996: 188). In other words, when we become emotionally distressed our normal information-processing abilities tend to become faulty because

we introduce a consistently negative bias into our thinking, thereby maintaining our problems. For example, a person who makes himself angry over not being invited to a party, denounces his friends as 'bastards and backstabbers' and declares he will 'get them back for humiliating me' fails to consider other reasons for not being invited (for example, he becomes aggressive when he has had too much to drink). Distorted thinking underlies all psychological disturbances (Ledley et al., 2005). These distortions usually stem from underlying dysfunctional beliefs that are activated during emotional distress, e.g. a person experiencing depression after the break-up of his relationship insists 'I'll always be alone' (fortune-telling) because he believes he is unattractive (core belief).

Common information-processing distortions or biases include:

- **All-or-nothing thinking:** Situations are viewed in either/or terms (e.g. 'Either you're a success or failure in life. There is no in-between').
- **Mind-reading:** You believe you can discern the thoughts of others without any accompanying evidence (e.g. 'She doesn't have to tell me – I know she thinks I'm an idiot').
- **Labelling:** Instead of labelling only the behaviour, you attach the label to yourself (e.g. 'I failed to get the job, so that makes me a failure').
- **Jumping to conclusions:** Drawing conclusions on the basis of inadequate information (e.g. 'My girlfriend didn't phone when she was supposed to, so she must be going off me').
- **Emotional reasoning:** Assuming that your feelings are facts (e.g. 'I feel a phoney for not being able to answer the question, so I must be one').

Teaching clients how to identify and change these cognitive distortions (or errors as they are sometimes called) facilitates the return of information-processing that is more flexible, accurate, evidence-based and relative (non-absolute) in its appraisal of events.[2]

[2] Gilbert (2000) objects to the word 'error' as it implies there is a correct way of thinking ('the client is wrong and the counsellor is right'). To sidestep this thorny issue, he suggests using non-contentious expressions such as 'anxious thoughts' or 'depressive thoughts' instead of 'cognitive errors'.

Hierarchical organization of thinking

The cognitive model of emotional disorders advances three levels of thinking to be examined and modified.

1 Negative automatic thoughts (NATs)

These are thoughts that come rapidly, automatically and involuntarily to mind when a person is stressed or upset (Gilbert [2000] calls them 'pop-up thoughts') and seem plausible at the time. NATs can be triggered by external events (e.g. late for a meeting: 'They'll think badly of me. My opinion won't count. I'll lose their respect') and/or internal events (e.g. pounding heart: 'I'm having a heart attack. I'm going to die. Oh God!'). NATs are situation-specific and the easiest cognitions to gain access to by asking the 'cardinal question of cognitive therapy: What was just going through my mind?' (J. S. Beck, 1995: 10). NATs can also occur as images, such as a person seeing himself 'dying of embarrassment' if he makes a faux pas when he is the best man at his friend's wedding. The clinical focus at this level is twofold: what we think (specific NATs in specific situations) and how we think, i.e. ways of processing information which result in some of the cognitive distortions listed above. Three general questions can be used in attempting to modify NATs (Dobson and Dobson, 2009):

1 What is the evidence for and against this thought?
2 What are the alternative ways to think in this situation?
3 What are the implications of thinking this way?

2 Underlying assumptions/rules

These are the often unarticulated assumptions that guide our everyday behaviour, set our standards and values, and establish our rules for living. A positive assumption might be 'If I work hard then I will be a success in life' and an accompanying negative assumption (the reverse side of the positive one) might be 'If I slacken in any way then I will be a failure'. Underlying assumptions are often identified by their 'if … then' or 'unless … then' construction (for example, 'Unless I'm