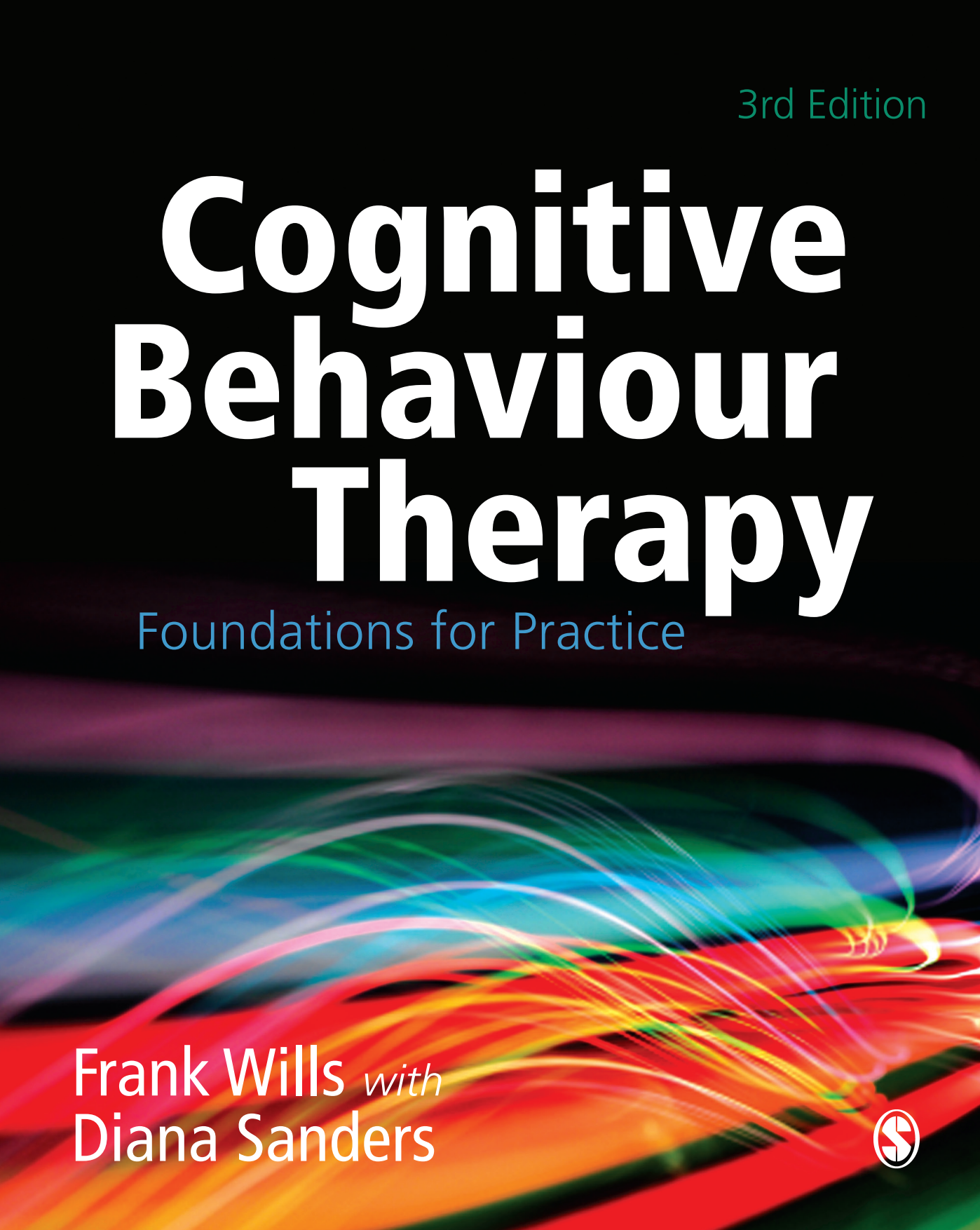
3rd Edition

# Cognitive Behaviour Therapy

## Foundations for Practice



Frank Wills *with*
Diana Sanders

# Cognitive Behaviour Therapy

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# Contents

# Preface to the Third Edition

As we engaged in writing this third edition of our book first published in 1997, we have realised that cognitive behaviour therapy (CBT) is on the march – perhaps even 'at the double'. There have been numerous new developments and changes since we both trained in CBT in the early 1990s and the pace of change shows no signs of easing. It has been challenging to write an account of the model that retains its basic integrity but also reflects developing diversity within it. We were both trainees in one of the early cohorts of the Oxford Cognitive Therapy training course – a veritable engine room for CBT development in the UK. Even as we wrote the first edition of this book, *Cognitive Therapy: Transforming the Image*, in 1997 a major new development was evident in schema-focused therapy (SFT) and first attempts to address interpersonal and characterological issues. As we wrote the second edition in 2004–5, we had to think about how the transdiagnostic and metacognitive approaches and mindfulness-based cognitive therapy (MBCT) were to be understood and incorporated into a coherent model of practice. We were also noticing the first stirrings of acceptance and commitment therapy (ACT) and compassion-focused therapy (CFT) and contemplating what they had to say. Now as we come to submit this third edition in late 2011 we have seen yet more development in all these trends plus what we have called the 'late flowering' of the new behavioural approach. It is possible to see in all this diversity parallels with trends within the historical development of other models such as psychoanalysis and humanistic therapy. One can also recognise the same potential for schism and infighting and wonder if the overall integrity of CBT can be retained. Our approach has been to 'keep our powder dry' and not to over-react in the face of potential fracturing. We have no doubt that important points of development are raised in many of the new 'waves' of CBT and that they can be enthusiastically embraced, but they should not be uncritically embraced. There are other motives, including academic kudos, involved in developing new 'products'. Psychological therapy is such a fundamentally difficult activity that all of us sometimes think that if only we had one more theory or technique up our sleeves we would finally have it all sown up. We still, after 30 and 40 years of practice respectively, think this – life-long learning indeed! We have been very aware that alongside the production

of 'waves' of CBT there has also been fearful consumer reactions that one will not be included in the 'latest thing' and suddenly find oneself passé, fallen and trampled down by rush of people literally running to avoid exclusion from the 'hot' conference workshop. This edition then focuses on retaining the integrity and parsimony of the original CBT approach whilst making appropriate assimilation from new developments from both CBT and other therapeutic models. We will return to these themes to assess how well we think we have managed this testing task in the Epilogue of this book.

*A note on authorship*: For this edition Diana has mainly contributed material on MBCT so that Frank has taken more responsibility for writing the rest of the book. Whilst both authors take responsibility for its overall thrust, there are inevitably small differences of emphasis at times.

## ACKNOWLEDGEMENTS

We would like to acknowledge the following colleagues and friends who have helped us with this edition – some are 'the usual suspects', others new. We thank them with all our hearts: Sheila Brennan, Mo Chandler, Amanda Cole, Elaine Davies, Janet Gray, Alice Oven, Kim Richardson, Christina Surawy, Kate Wharton, Mark Williams, Annie Wills and, of course, each other.

# PART I

## COGNITIVE BEHAVIOUR THERAPY – THEORY, MODEL AND STRUCTURE

# 1

# CBT: A Developing Model

Cognitive behaviour therapy (CBT), as developed by A.T. Beck and others, is built on the assumption that thinking processes both influence and are influenced by emotional and behavioural responses in many different psychological problems. Therapy therefore aims to modify cognitive, emotional and behavioural processes in an experimental way to test whether modification has positive effects on the client's difficulties. While clients may come to therapy asking for help with their negative thoughts, more often they come because they are feeling bad. Despite its focus on thinking, CBT is actually all about reaching and working with emotion. Cognitions and cognitive processes are emphasised because they can often provide direct and useful paths to relevant emotions. Furthermore, understanding specific thoughts, styles and processes of thinking can go a long way to explain negative feelings to clients, who may well have been experiencing them as incomprehensible and frightening. The way in which cognition influences emotion and behaviour is at the heart of CBT and the basis of both the early models, developed in the 1970s, and current theory and practice.

Since the first models evolved, both the theory and practice of CBT have been subject to continual and accelerating change and development. In this chapter, we look first at the foundational model of theory and practice and then at the subsequent developments leading CBT to what it is today. Such developments are now multifarious and include integration of the interpersonal and the therapeutic relationship within both the theory and practice of CBT. In addition, contributions have come from behavioural and cognitive theorists that have added new dimensions through increased understanding of the role of cognitive and emotional processes in psychological disturbance (Wells, 2009) and mindfulness in psychological change (Segal et al., 2002). After almost 50 years, the theory and practice of CBT are still developing, with what has been called the 'third wave' hitting the beach (Hayes et al., 2004). The chapter ends by looking at some of these new contributions, the 'third wave', bringing an experiential focus, mindfulness and acceptance to the practice of CBT.

## FOUNDATIONS OF CBT

With his two major publications of the 1970s, *Cognitive Therapy and the Emotional Disorders* (1976) and *Cognitive Therapy of Depression* (Beck et al., 1979), Beck, and his colleagues, established what many now regard as the original model of CBT. The model contained a theory of how people develop emotional problems; a model of how they could heal disturbance; and a model of how further problems might be prevented. The links between emotion and cognition were initially most clearly demonstrated in the treatment of depression; opportunely because depression is often regarded as one of the most frequently presented psychological problems. The model was also supported by what was, for the psychotherapy field, an impressive range of research validation for both its underlying constructs and its outcomes.

### The Thought–Emotion Cycle

A key aim in CBT is to explore the meanings that clients give to situations, emotions or biology, often expressed in the client's 'negative automatic thoughts' (NATs). The valuable concept of *cognitive specificity* (see www.sagepub.co.uk/wills3 for material on this and related definitions) demonstrates how particular types of thoughts appraise the impact of events on the 'personal domain' (all the things we value and hold dear) and thereby lead to particular emotions, as shown in Table 1.1. It is then possible to discern the influence that such thoughts and feelings have over behaviours – especially 'emotion-driven behaviours' (Barlow et al., 2011a). The appraisal of 'danger' to our domain, for example, raises anxiety and primes us for evasive, defensive or other reactions. The appraisal of 'loss' is likely to invoke sadness and mourning behaviour. An appraisal discerning 'unfairness' is likely to arouse anger and may lead to an aggressive response.

In themselves, responses to negative appraisals are not necessarily problematic and indeed are often functional: for example, we all know that driving carries certain risks and being aware of those risks may, hopefully, make us better drivers. Our specific appraisals of events may begin to be more problematic, however, as they become more exaggerated. If we become preoccupied with the risks of driving, and see ourselves as likely to have an accident, then the emotion of slight, functional anxiety becomes one of unease or even panic. Furthermore, if this feeling increases, the chances that driving ability is adversely affected also increase. Similarly, we may

**TABLE 1.1** Key themes: cognitive specificity

| Appraisal | Emotion | Emotion-driven behaviour |
|---|---|---|
| Loss to domain | Sadness, depression | Search, mourn, grieve |
| Threat to domain | Fear, anxiety | Fight, flight, freeze |
| Violation of domain | Anger | Attack |
| Expansion to domain | Delight | Praise |

feel a certain comforting sadness about a loss in our life, but if we begin to see the loss as a major erosion of our being, we could then feel corrosive depression rather than relatively soulful melancholy. If the depression cycle goes on, we tend to become lifeless, lacking energy and enthusiasm, and are thereby less likely to engage in things that give our life meaning; as a result we become even more depressed. In another example, appraising meeting people as 'worrying' raises anxiety and primes evasion and defensiveness. If we become preoccupied with the risks of meeting people and making faux pas, then a sense of reasonable caution can become unease or even panic. Furthermore, if this feeling increases, the chances of our making faux pas may increase, which further increases our anxiety and so maintains the problem.

The essence of the model is that there is a reciprocal relationship between emotional difficulties and seeing events in a way that is exaggerated beyond the available evidence. These exaggerated ways of seeing things tend to exacerbate negative feelings and behaviour, and may constitute a vicious cycle of intensifying emotionally driven thoughts, feelings and behaviours (see Figure 1.1).

Critics sometimes wrongly regard CBT as being based on generalised formulae that claim people are disturbed by their thoughts. In fact, good CB therapists understand each client in a highly individualised way. Rather than reducing clients' mediating cognitions to formulaic sets of 'irrational beliefs', a CBT approach aims to understand why clients are appraising events in particular ways and why they feel the way that they do. In Epictetus' famous dictum – 'People are disturbed not by events themselves but by the view they take of events' – external and internal (i.e., thinking about something) events are important because they are usually the triggers that set off the whole cycle of reaction. The same event, however, may impact differently on different people because, first, each individual has a different personal domain on which events impinge. Second, each person has idiosyncratic ways of appraising events because cognitions, perceptions, beliefs and schemas will

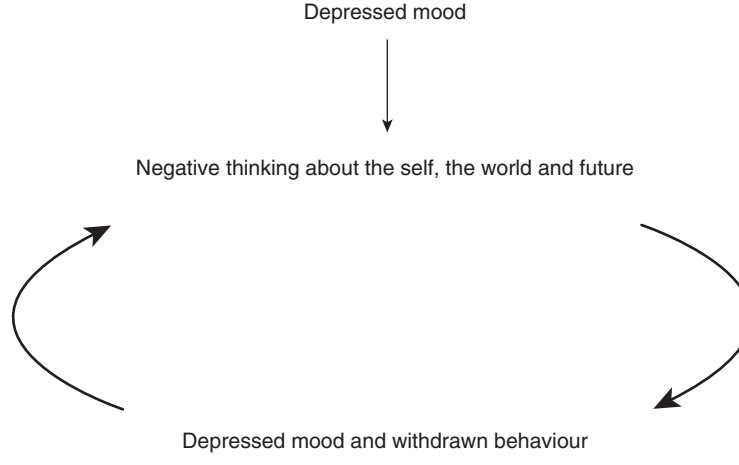


**FIGURE 1.1** A vicious cycle of thoughts, feelings and behaviour

have been shaped by that individual's unique personal experiences and life history. The aim of CBT is to understand both the client's personal domains and their idiosyncratic way of appraising events. Additionally, when we look to modify cognitions, it is probably impossible to completely erase negative thoughts. Pierson and Hayes (2007) make a valuable point when they say that it is not so much that clients have to *replace* a negative thought with a more functional one, but they are able to *follow* it with a more balanced thought – learning to allow the thought 'I am a failure' to be followed by another thought like 'Hang on, that's not the whole story!'. Another account of the process of cognitive change comes from Brewin et al. (2006), who suggests that different cognitions are available at any one point in time but some – the more functional ones – are often difficult for depressed clients to retrieve. In this account CBT does not directly change cognitions but rather changes the relationship between different cognitions in such a way that more helpful ones are retrieved.

While, on a simplistic level, a person's thoughts and emotions about an event may appear 'irrational,' the response may be entirely rational, given his way of seeing the world. As we look at new developments in CBT, we will see that it may be that the content of the thinking itself is not so problematic. It turns out that, perhaps in a good, democratic fashion, 'irrational' content is by no means confined to people with psychological problems. For example, the thoughts that are problematic for clients with obsessive-compulsive disorder (OCD) are shared by 90 per cent of the population (Rachman, 2003). OCD sufferers, however, pay attention to these thoughts in a different way. Non-sufferers can let them go: OCD sufferers cannot. Similarly, it seems that most people at times have the kind of intrusive thoughts that are a problem for 'worriers' (Leahy, 2005). People vulnerable to worry, however, will focus more time and attention onto the worries and will be less able to let them go (Wells, 2009).

## Cognitive Distortions: Negative Thoughts

Cognitive themes are expressed in specific thoughts. Rather than thinking in literal sentences, such as 'There is a loss to my personal domain', such themes are expressed in situationally specific cognitions (e.g., 'He finds me dull') that, when added together, amount to a theme (e.g., 'People find me tedious'). These themes become elaborated and maintained by the day-to-day 'dripping tap' effect of the client's 'negative automatic thoughts' (NATs). Often the client is barely aware of these thoughts until they are highlighted. Beck (1976/1989) discovered the constant commentary of negative thoughts when a client became anxious while talking about past sexual experiences. The client, however, revealed that it was not the fact of describing these experiences that was causing the emotional pain but rather the thought that Beck would think her 'boring'. In depression, thinking has a

characteristically negative and global tone centred on loss – not just of loved objects but of a sense of self-esteem and, crucially, for depression, a sense of loss of hopefulness about the world and the future. The triangle of negative views of self, of the world and the future comprise Beck et al.'s (1979) 'cognitive triad', in which the dynamics of depression operate.

In an early publication Beck (1976/1989) described a range of cognitive distortions, shown in Table 1.2. For example, the thought, 'I'm stupid', a common negative automatic thought in emotional disturbance, betrays 'all-or-nothing' thinking because it usually refers to a narrower reality – that people occasionally do some things which, with the benefit of hindsight, may be construed as 'stupid'. Depressed clients, however, will often go on to the globalised conclusion that this makes them a 'stupid person'. In this type of dichotomous reasoning, there are only two possible conditions: doing everything right and being 'not stupid' or doing some things wrongly and being 'stupid'. Thus the negatively biased person uses self-blame, thereby depressing mood even further in a vicious cycle.

In CBT, clients and therapists work collaboratively to identify and label negative thoughts and to understand how thoughts interact with emotions to produce 'vicious cycles'. These are the first steps that enable clients to understand their emotions. When clients detect specific thoughts, it can be useful to ask them what effect these repetitive thoughts will have on their mood. Many clients will conclude that such thinking is bound to get them down. Thus the simplest form of the cognitive behavioural model links thoughts and emotions most relevant – salient – to clients' situations. Therapists can then look at the degree of 'fit' between thought and feeling – does the thought make sense of the feeling? Looking at Table 1.2, if you had the thought, 'I will lose my job', would you be likely to feel anxious and worried? Clients may also have 'favourite distortions' – and this may allow them to take the helpful 'mentalisation' (being able to understand the mental state of oneself or others) step whereby they can say to themselves 'There I go – personalising things again!' As we will describe later such steps may be part of a wider ability to look at, defuse or decentre from negative thoughts from a new, more mindful position.

## From Thoughts to Schemas

NATs are unhelpful cognitions closest to the surface of consciousness and may refer only to a limited range of situations. Beck recognised, however, that there were also deeper cognitions that incline the person to interpret wider ranges of events in relatively fixed patterns. Originally Beck used the term 'constructs' (Kelly, 1955) to describe deeper cognitive processes but then preferred the term 'schemas' used by earlier psychologists (Bartlett, 1932) to describe them.

Schemas are not, of course, all problematic. For example, Bowlby (1969) describes how children who have experienced satisfactory attachment and bonding to primary

**TABLE 1.2** Common thinking biases

| Type of thought | Description and examples |
|---|---|
| Black-and-white thinking | Seeing things in black-and-white, all-or-nothing categories, missing the 'grey' areas:<br>'*I don't measure up*' (see Mary, p. 15)<br>'*Everyone else gets it right'* |
| Mind-reading | Concluding that other people are thinking a certain way:<br>'*People must think I'm really stupid'*<br>'*Everyone thinks I'm boring'* |
| Crystal ball gazing | Looking into the future and making predictions:<br>'*I will lose my job*' (see Keith, p. 11)<br>'*She will leave me*' (see Ben, p. 12) |
| Over-generalisation | Seeing a negative event as an indication of everything being negative:<br>'*I didn't get the job – I guess I'll never get another job again'* |
| Mental filter | Picking out a single negative feature and dwelling on it without reference to any good things which might have happened:<br>'*I had an awful day, my computer crashed and I couldn't do anything for the rest of the day*' |
| Disqualifying, minimising the positive | Recognising something good in yourself or your life and rejecting it as invalid or unimportant:<br>'*I'm a good mother to my kids but that doesn't matter, anyone can do that*'<br>Or shrinking it inappropriately:<br>'*I've been promoted at work, but it is not a top firm so it doesn't count*' |
| Magnification or 'drama queen' | Exaggerating the importance/significance of events:<br>'*I've got a pain in my chest, it must mean I'm having a heart attack and am going to die'*<br>'*I can't find my keys, I must be losing my mind'* |
| Emotional reasoning | Assuming that what you feel is true:<br>'*I feel like a bad person, I must be a bad person'*<br>'*I feel like I'm dying so I must be'* |
| Unrealistic expectations | Using exaggerated performance criteria for yourself and others. Using 'shoulds' and 'oughts' in your expectations of yourself and your demands of others:<br>'*I should always be interesting when talking to other people'*<br>'*I must keep going even though I'm tired'* |
| Name-calling and labelling | Attaching a highly emotional negative label to yourself or to others:<br>'*Idiot'*<br>'*Silly cow'* |
| Self-blame | Seeing yourself as the cause of a bad event for which you were not responsible:<br>'*She's looking cross, I must have upset her*' |
| Catastrophising | Predicting the very worst:<br>*'Nothing is ever going to work out for me again'*<br>*'This lump in my neck must be cancer, the treatment won't work and I'll die a horrible death'* |

caregivers will develop a basic set of rules or schemas that contain the inner working model that 'people can generally be trusted'. If people with 'trust schemas' meet untrustworthy behaviour in others, they are likely to think 'Something went wrong there, I may have to be more cautious in future', which is an adaptive response. When people with 'mistrust' schemas encounter untrustworthy behaviour, however, they

are likely to conclude 'I was right. You can't trust anyone. I won't do so again', which is an overgeneralised and, therefore, less adaptive response.

Negative schemas are seen as underlying NATs. Unhelpful assumptions – conditional core beliefs – are operationalised into 'rules of living' and sometimes termed 'intermediate beliefs'. They are contained within schemas, are triggered by events and lead to NATs. Sometimes the assumptions persist after NATs and the other symptoms of depression have abated and may then be targeted as a method of preventing later relapse back into depression. Whilst these different levels of cognition are conceptually clear, in practice they are usually identified from client self-reports and therefore it is not always easy to know if the thought 'I am a failure' is truly a core belief or a thought that applies to only limited situations.

As CBT developed, schemas were given a more significant and autonomous role in therapy. It is important to remember when working with schemas that they are not concrete objects and may be better understood as 'schematic processes'. It has been difficult for CBT researchers to show the autonomous existence of these processes but the schema concept remains a useful one (Wells, 2000).

So far we have established that there are strong links between thought and feeling. We do not argue, as Beck did not, that they are *causal* links, but are best understood as two-way processes. Clients are likely to experience the links in this reciprocal way. Thoughts and feelings are often experienced as a unitary phenomenon, so it is likely that our labelling of 'thought' and 'feeling' is more a useful heuristic (speculative formulation to guide investigation and/or problem-solving) device for therapy than a truly knowable reality. Although our Figures and Tables are also heuristic devices and show clear relationships between thoughts and feelings, it is increasingly realised that the actual sequences are highly complex (Le Doux, 1998).

## The Role of Behaviour in Disturbance

Problematic behaviours are best understood in relation to their role in reciprocal reinforcement in the vicious cycle by way of thoughts, feelings and actions. Thoughts and emotions have built-in action dispositions, so that behaviours may seem to come as instantaneous reactions – 'I could have kissed him'. Often, becoming aware of thoughts and feelings accompanying behaviour is helpful to clients, enabling them to respond with less automaticity and therefore less problematically. Equally, behaviours have independent effects on thoughts and feelings. 'Act as if' we felt confident can result in feeling more confident, so that a client can learn 'to act his way into a new feeling' (Izard, 1971: 410). Behavioural responses often play the role of final link in the chain, locking and maintaining the whole sequence of thoughts, feelings and behaviours into persistent, and unhelpful, patterns. This often happens because the concrete behaviours produce environmental

consequences: see the examples of linked negative thoughts, feelings, behaviours and consequences that follow. In the first example, the sequence mainly affects the client's internal experiences, while the second has notably interpersonal affects.

**CASE STUDY**
**Keith**

Keith was a 40-year-old IT project manager in the Civil Service and had experienced recurrent dysthymia since his teenage years. His current depression had lasted for 2 years, since the threat that his work section would be outsourced. He worked hard but was isolated at work, often staying late and taking work home. He considered that his performance had deteriorated, making him vulnerable to redundancy. Keith's pattern is shown in Figure 1.2.

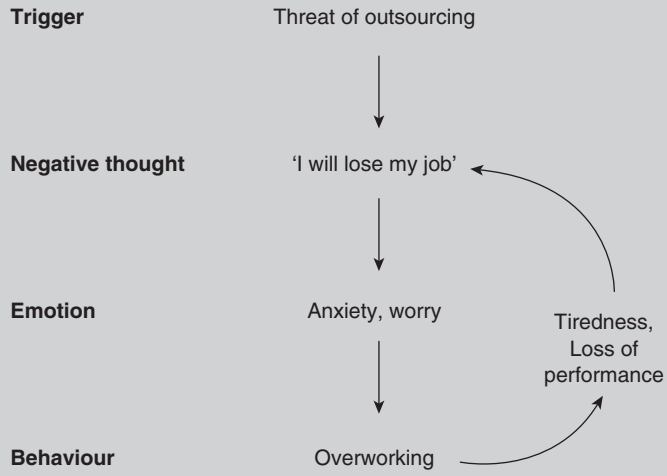


**FIGURE 1.2** Keith's vicious cycle

**CASE STUDY**
**Ben**

Ben's mother died when he was 12 years old. He came to believe that 'Nothing lasts – people leave you'. Now when he meets potential girlfriends he feels anxious because he cannot help imagining them leaving him. He then tends to become 'over the top' – endlessly and dramatically declaring his love – with the ironic consequence of making his girlfriends uneasy and less likely to stay in the relationship. Ben's vicious cycle is shown in Figure 1.3.

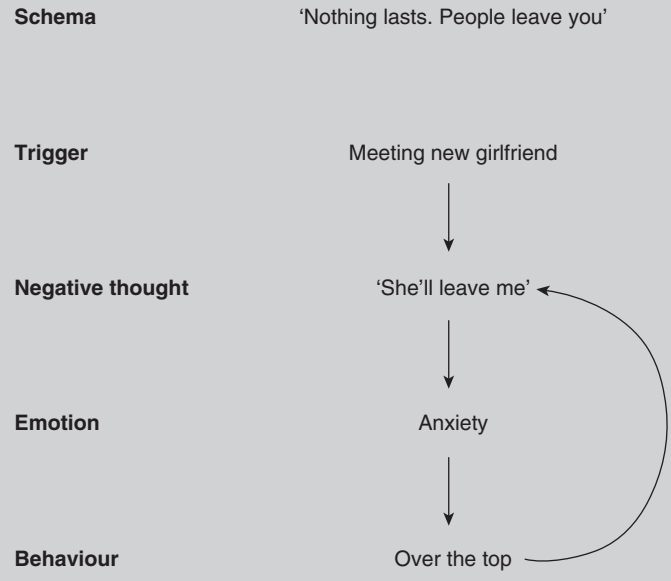


**FIGURE 1.3** Ben's vicious cycle

Clients are often puzzled by their emotional and behavioural responses to situations – 'I cannot understand why I get drawn into doing that' is a common reaction. The whole cycle of thought, feeling and behaviour is made more concrete and understandable when therapist and client actually draw the vicious cycle onto paper or whiteboard. This can mark beginnings of formulation. Concreteness and clarity in formulation enhance the prospects of change. Formulating diagrams may be given to clients to take home and think about or work on, perhaps as homework assignments. The process of formulation is described in detail in Chapter 3. Formulation diagrams can extend to wider uses in therapy, including linking different parts of the vicious cycle to potential therapeutic goals and targets (see Figure 1.4).

Behavioural approaches in CBT have been refreshed by the 'new behaviourism', which has added strong new concepts and methods to our work: these will be described throughout the book and especially in Chapter 6.

## The Original Model of the Therapeutic Relationship

CBT aims to be an accessible and practical mode of therapy, one that can be related to pragmatic common sense (Wills, 2009). One attraction is its immediacy, achieved by the way the model fits with the client's experience. Formulation often

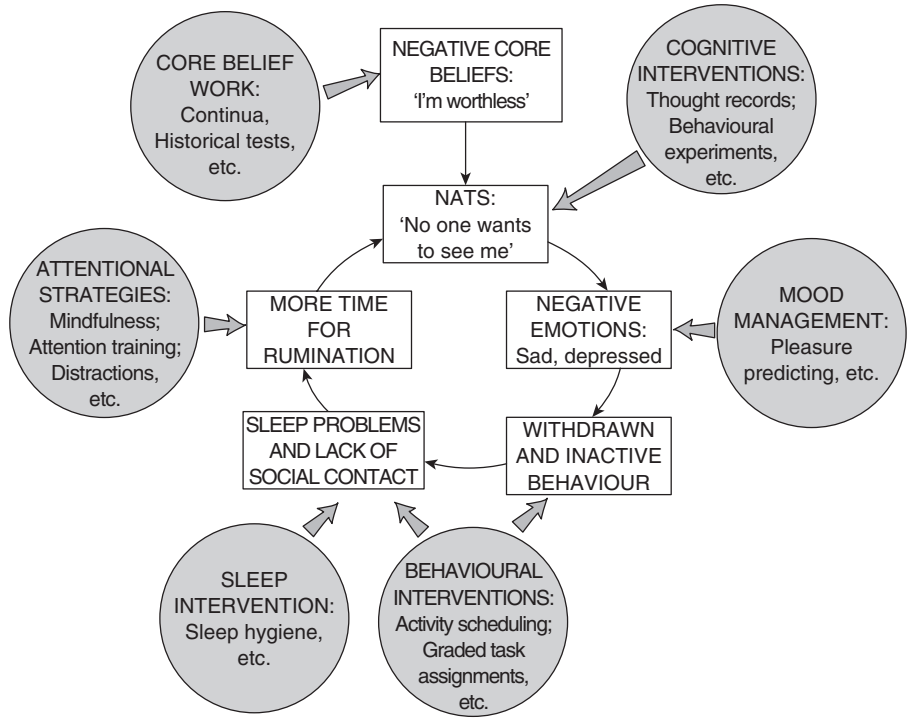


**FIGURE 1.4** Vicious cycle with therapy targets (Dryden & Branch, 2011)

appears relatively simple and straightforward to students of the approach. CBT terminology may sometimes belie the complexities and sophistication of the model. It is congruence between the model and clients' experience, however, that enables the therapy to make sense to them. The basic therapeutic processes of CBT specified in early models and largely continued in recent developments involve three interacting elements: a *collaborative therapeutic relationship*, a *scientific, empirical method* and a *parsimonious form of therapy*.

In Chapter 3 of *Cognitive Therapy of Depression*, Beck and colleagues describe a view of the *therapeutic relationship* which draws heavily from Carl Rogers, stressing the 'core conditions' of 'warmth, accurate empathy and genuineness' (1979: 45). They add, however, that these conditions are not in themselves sufficient to produce optimum therapeutic effect. Trust, rapport and collaboration are also needed. It is the concept of collaborative empiricism that marks the point of departure from Rogers:

> In contrast to 'supportive' or 'relationship' therapy, the therapeutic relationship is not used simply as the instrument to alleviate suffering but as a vehicle to facilitate

> a common effort in carrying out specific goals. In this sense, the therapist and the [client] form a 'team'. (Beck et al., 1979: 54)

The emphasis is on a working relationship: one that perhaps carries with it a little of the Protestant work ethic, and offers a contrast to therapies which stress the importance of 'being' rather than 'doing' in the relationship with the client – though with advent of mindfulness into CBT, this balance could be shifting. The nature of the cognitive and behavioural work to be undertaken is that of identifying and modifying unhelpful cognitive and behavioural processes respectively. More recently there has also been increased emphasis on the need for 'interpersonal sensitivity' in CBT (Wills, 2008a).

A second axiom of the therapy process concerns CBT as *a scientific and empirical form of therapy*. The client's problem is first collaboratively assessed, and then therapy proceeds from the findings of this assessment. As will be discussed in greater detail in Chapter 3, assessment involves full understanding of the presenting symptoms and underlying factors, allowing a clear direction for the therapy. The 'base line' of current functioning is established so that the outcome of therapy can be monitored, using tools such as the Beck measures for depression – the Beck depression inventory (BDI) – and for anxiety – the Beck anxiety inventory (BAI). By the time the usual allocation of around 12–20 sessions (for depression; 5–12 for anxiety) is coming to an end, the scores should be considerably reduced.[1] CBT can be regarded as a series of scientific 'single case experiments' (Kirk, 1989). The monitoring of therapy should not be determined by dogmatic use of tick-box scores, however: it also needs to take account of client feedback and other factors. A final aspect of the scientific approach is the *relatively*[2] standardised form of therapy. The degree to which the therapist appropriately stays with prescribed interventions and yet also applies them individually and artfully nearly always varies. Competence in the use of CBT skills is assessed using measures such as the Cognitive Therapy Scale (CTS) and its revisions (Young & Beck, 1980, 1988; James et al., 2000) – though much remains to be learnt in this area (Wills, 2010). Measures of competence ensure that CBT is conducted with *relative* consistency across different settings of therapy.

The third aspect of the therapy process is the relative *parsimony* (achieving the greatest benefit from the least effort) of CBT. Parsimony involves commencing work at symptom level and advancing to work on the level of underlying belief as appropriate: such as, when 'historical' issues keep coming up or when clients themselves want to work at that level. A typical example of parsimonious treatment is seen in the use of behavioural activation with depressed clients, for whom behavioural withdrawal is often a profound cycle which reinforces the maintenance of low mood and depression. Additionally, clients may initially be too depressed for cognitive 'insight' interventions. Therefore, CBT with depressed clients often starts

at the behavioural level, moving to working on cognitions and underlying assumptions and beliefs when behavioural approaches have produced some improvement in mood (Fennell, 1989). Clients would typically be encouraged to schedule activities and then try to insert more 'achievement' and 'enjoyment' into their days. The overall aims of these behavioural tasks and experiments are to engage in constructive behaviour and to loosen the grip of 'depressogenic' thinking. Pleasurable activity is helpful in its own right but can also be used to test and disconfirm clients' NATs, such as 'I never enjoy things any more'. It is usually more possible then to address negative thoughts and beliefs directly as mood lifts.

The parsimonious approach is also evident in the recommendation that therapists start work at the most accessible level of cognition – that of automatic thoughts – and only later work at the deeper levels of assumptions, core beliefs and schemas. The great array of both behavioural and cognitive techniques gives flexibility to 'mix and match' therapeutic interventions. Good CBT should, however, always be carefully fitted to the needs and wishes of the individual client, and this allows therapy to proceed in a way that is highly interpersonally sensitive (Wills, 2008a).

## THE DEVELOPING CBT MODEL

Since Beck's original cognitive model of psychological problems, a number of new ways of thinking about psychological processes have been integrated into CBT. One area of development concerns the integration of an interpersonal perspective into the model (Gilbert & Leahy, 2007; Wills, 2008a). Other developments have seen more explicit integration of work on 'transdiagnostic' cognitive processes into CBT (Harvey et al., 2004; Barlow et al., 2011a) and that of meta-cognitive therapy (Wells, 2009), acceptance-based and mindfulness-based models (Hayes et al., 2004; Segal et al., 2002).

### Interpersonal Processes and the CBT Model

Various authors (Safran & Muran, 2000; Gilbert & Leahy, 2007; Wills, 2008a) have emphasised how the client's issues outside therapy can be worked through in the therapeutic relationship itself. They follow on from the earlier work of Guidano and Liotti (1983) and especially integrating Bowlby's (1969, 1973) attachment theory into CBT (Liotti, 2007). These approaches recognise the strong imperative for humans to relate to each other. Relatedness and affiliation have crucial survival value not only to the infant during the long period of dependency but also to all

of us, as our lives are usually dependent on large degrees of social cooperation. Attachment behaviour is seen as a 'wired-in' propensity of human behaviour, evident right from the first moments of a newborn baby's experience. Infants quickly develop the ability to send and receive attachment-based communications with caregivers. Misattunements in attachment information, if persistent, can have a highly negative effect on development. A key process in attachment is that children seem to learn emotional regulation styles from caregivers (Leahy, 2011) – a factor that seems to inextricably link two key elements in 'emotionally sensitive CBT' (Wills, 2008a).

As a result of our imperative to relate, many core beliefs and assumptions about life and the world are likely to be interpersonal (Wills, 2008a). Attachment schemas are internalised and may become persistent, independently of subsequent experience. They can therefore become locked into a cognitive-interpersonal style.

**CASE STUDY**
**Mary**

Mary remembered her childhood as one in which she did not get the parental recognition that her siblings did. She summed this up in the core belief 'I do not measure up'. Consequently she developed a strong desire to please others during her childhood. Forty years later, she could not understand why work colleagues 'didn't respect her'. Her tactic was to try hard to please them and to win their respect. Unfortunately, as often happens with this tactic, it made her colleagues irritated and actually less respectful of her. Her overly pleasing behaviour was also evident in the therapy room, but here we were able to reflect on its nature and significance in a non-judgemental way.

As Harry Stack Sullivan (1954) pointed out, clients' attempted solutions may be part of the problem: that is, clients, understandably, try to counter unhelpful beliefs, yet in ways that only lead to their perpetuation. Therapists' assessments include appraisal of how pervasive these patterns are and whether they are replayed within the therapeutic relationship itself. Wills (2008a) suggests that therapists need to be aware of 'interpersonal signals', not only because awareness facilitates the therapeutic process but also because such signals can prove reliable guides to the contours of the client's interpersonal terrain. We turn again to Mary. The first time that the therapist met Mary, she asked a lot about his qualifications. The therapist made a standard interpretation of her actions: that they might conceal an anxiety about trust. In a later discussion, however, Mary explained that her inquiries were linked to her cognitive-interpersonal belief that 'People will only be interested in me if I am even more

interested in them first'. In training on sales techniques, she had been taught that customers were more likely to buy from her if she showed interest in them first. A look back at the previous extract on her childhood shows how well this belief fitted into her existing cognitive-interpersonal schema 'I am only able to gain love and respect by pleasing people'. Wills (2008a) argues that interpersonally sensitive CBT is also founded on a thorough understanding of the therapeutic significance of 'felt meaning' and the deep emotions of affiliation. It should now be recognised that there was at least a grain of truth in criticism that earlier models of CBT were overly rationalistic and utilitarian in their approach, often seeming to view painful emotion as something to be 'brought under control'. There has, however, been a growing realisation in most forms of CBT that, as Beck has long said, emotion is the key to successful therapy and further that attempts to 'control' emotions often have unintended negative consequences. Even negative emotions such as depression can serve the purpose of directing attention to difficult areas in clients' lives; the problem is not so much that such emotions occur but that they persist longer than is helpful to clients.

The omnipresence of emotionally significant material in therapy can be linked to the importance of interpersonal schemas. These schemas are likely to have been encoded in highly emotional ways, so unless the therapeutic process activates these emotions, processing cold meaning alone is unlikely to have much therapeutic impact. Salient interpersonal beliefs may have been established in the client's earliest days and therefore influential material is encoded in non-verbal ways (see 'The Cloud' on pp. 231-2). Non-verbally encoded meanings may be left untouched by directly verbal interventions. This again highlights the role of the therapeutic relationship, especially as a context within which 'interpersonal signals' may be reviewed as possible samples of clients' interpersonal styles. The importance of interpersonal schemas and their role in the therapeutic relationship can now be more fully integrated into CBT. This changes CBT from being a therapy in which the therapist could appear as the stereotyped cool, detached, logic-chopping technician, to a therapy in which '*feeling* and thinking and behaving' are *all* central concerns. Therapists must have crucial awareness of how the clients' issues may be acted out in the 'here and now' of the therapeutic relationship itself, as well as in clients' lives outside therapy. Such awareness demands self-knowledge; awareness was emphasised more commonly in other therapies but is now also recognised in CBT (Bennett-Levy, 2001; Grant et al., 2004). A new impetus has also come from new behavioural models of how psychological change can be enhanced by clearer recognition of the therapist's interpersonally rewarding qualities (Tsai et al., 2009) and the benefits of 'disciplined personal involvement' with clients (McCullough, 2006).

In many ways, however, these new developments leave much of the original structure of CBT as it was. The difference lies in the quality of what goes on inside

that structure. Although the interpersonal model of CBT is still developing, significant accounts of it are emerging as 'compassion-focused therapy' (Gilbert, 2009) and 'interpersonally sensitive CBT' (Wills, 2008a). Further description of all the strands of this developing approach to the therapy relationship in CBT follows in Chapters 3, 7 and 8.

## Working with Cognitive Processes

CBT has developed new directions by adding to the previous focus on cognitive content (e.g., 'Something bad will happen') an additional focus on cognitive *processes* (e.g., spending unhelpfully long periods of time worrying that something bad will happen). CBT has increasingly elaborated on how these processes effect the development, maintenance and treatment of psychological problems. To some extent, this focus was evident even in Beck's early writing on 'fixation' (Beck, 1976/1989) and then in the highlighting of processes such as cognitive avoidance in anxiety, and in how rumination (continually thinking and worrying) maintains depression. Cognitive processes have moved more centre-stage as the roles of physiology in anxiety, and of meta-cognition ('thinking about thinking'), mindfulness and attention have been clarified. These new developments also chime in with parallel thinking on the need to enhance processes of acceptance, commitment and change, discussed in the final sections of this chapter.

**CASE STUDY**
**Kevin**

Kevin was a student nurse, prone to panic attacks. When he felt his pulse suddenly racing, he thought that he would collapse and believed that collapsing would lead colleagues to conclude that he could not do his job. Such catastrophic thoughts led to a growing sense of panic, with increasing physical symptoms to match. He then used safety behaviour: he sat down. After a worrisome half hour, the symptoms began to subside. Because he had not collapsed, he deduced that he had a 'near miss': sitting down saved him. This meant, however, that he could not learn that he probably never would have collapsed, and even if he had, this would not have led to the catastrophe he feared. His panic-inducing belief therefore remained intact to strike again another day. The role of physiology is also important in formulating depression, as the next example illustrates.

**CASE STUDY**
**Jim**

Jim reported that every morning he awoke feeling physically uncomfortable, stiff and 'down' and habitually thought 'Oh no, not another day feeling shit'. In response to his therapist's suggestion to 'postpone worry' until later in the morning, he found he could step back and monitor the feeling more closely, he realised that he often felt some bladder or bowel discomfort because he needed the toilet. When he went to the toilet and simply got ready for the day, he noticed that he felt less uncomfortable and 'down'. He usually forgot to return to his worry later and could then resist making negative predictions about the rest of the day. He also discussed his physical sensations on waking with his wife. Although she did not get such symptoms, she reported feeling tired in the early evening. As Jim felt better in the evening, he could redefine himself as 'different from' rather than 'inferior to' his wife. These two pieces of learning helped him to get out of the vicious cycle of depression.

### Cognition and physiology

Physiological factors have always played an important role in the cognitive model, particularly in understanding anxiety (Clark & Beck, 2010). Models of anxiety have looked in greater detail at the way people interpret bodily cues (interoception), which has been shown to play a key role in panic attacks (Clark, 1986). People prone to panic attacks tend to make catastrophic interpretations of normal bodily symptoms. They are often prevented from learning that these symptoms are normal and benign by using 'safety behaviours' (Salkovskis, 1996). The following examples above illustrate how thinking about physical symptoms may be integrated into the cognitive behavioural model.

### Metacognition

Traditionally, CBT has worked with the language (declarative) content of negative thoughts and beliefs. When new therapists first try cognitive methods, they often report the difficulty that the client may report being *intellectually convinced* that, for example, they are not 'stupid', yet may not be 'emotionally convinced' and thus will continue to 'feel as if' they are stupid (Dryden, 2006). This may be because traditional CBT methods that challenge the content of thought only touch the output of relevant cognitive processes, whereas it would be more effective to address the processes themselves to explore how people arrive at what they 'know'.

Metacognitive therapy includes analysis of the role individuals' thinking about their thinking plays in the development of psychological problems. For example,

clients who are anxious usually have numerous negative, anxiogenic thoughts. What is of interest is not simply the content and meaning of specific thoughts, but the meaning of thinking in this particular way. Wells (2009) distinguishes between direct (type 1) worries, such as 'I will never be well again', and metacognitive (type 2) worries, such as 'Worrying like this will fry my brain'. As well as these negative metacognitive worries, problems can also be maintained by 'positive' metacognitive beliefs such as 'Worrying keeps me from nasty surprises'. Wells (2009) offers formulations and treatment plans based on a meta-cognitive perspective for a range of problems in depression and the anxiety disorders. The case of Sasha, a 43-year-old insurance clerk, illustrates this process.

**CASE STUDY**
**Sasha**

Sasha woke up worrying about the day to come, and went to bed worrying about what had happened in the day and what might happen the next day. Therapy initially focused on the distorted content of these worries, and helped her challenge her thinking. She reported that the process of evaluating her thoughts made sense in her head, but she continued to feel awful, worrying as much as ever. Therapy then moved to a metacognitive level, looking at the meaning of her worrying thoughts. She believed that not worrying would mean the things that got to her would be more likely to happen. Worrying alerted her to react quicker and would prevent terrible things happening in the first place. If she were not to attend to her worries, she might forget to do important things. Stepping outside her thought content to look at the meaning of the process was necessary before Sasha could begin to change her worry patterns.

Rachman (2003) and Salkovskis et al. (1998) offer similar analyses for clients with obsessive-compulsive difficulties, where clients believe that the fact they have 'bad thoughts' is in itself significant, proving something 'bad' about them. Bad thoughts are given enhanced significance and taken as indicating that something bad might happen, reflecting the client's excessive degree of personal responsibility for harm to self or others (Salkovskis et al., 1998). These clients often combine ritualistic behaviours, such as compulsive washing or checking, with 'neutralising', such as trying to stop the thoughts or replace 'bad' with 'good' ones. They are thus prevented from learning that the thoughts are normal, insignificant and harmless. As well as working on the specific content of thoughts, analysis of the meaning of thought processes is an additional effective and fruitful intervention.

**CASE STUDY**
**Christopher**

Christopher felt plagued with anxiety after walking past people in the street and imagining them slipping on the pavement and hurting themselves. He felt very guilty, believing that the fact he had those thoughts was as good as him wanting the accident to happen, and may even have increased the chance of accidents for which he would be responsible. If people were to slip and hurt themselves, he would not only be responsible for injury to them, but doubly responsible because he had failed to prevent catastrophe. Christopher tried to assuage his guilt by praying several times an hour.

### Attentional processes and mindfulness

Shifts in perspective that help us to feel better often have a degree of mystery about them. One day we may feel preoccupied by a glitch in our lives that is going less well than we would like; yet another day we can think, as one client once put it, 'Well, it is a sunny day after all'. The ability to step back from negative thinking in a liberating way – 'decentering from' or 'defusing' it in the technical terminology – is one that comes and goes for most of us. The decentering manoeuvre, however, is particularly difficult to achieve when we are mired in the ruminative thinking so prominent in anxiety disorders and depression.

**CASE STUDY**
**Sally**

Sally suffered from a disabling combination of panic attacks and health anxiety. Interventions aimed to change the way she paid attention to her 'symptoms' at the start of the day were part of treatment designed to reduce the overall effects of these problems. Rather like Jim, presented earlier in this chapter, Sally often awoke immediately experiencing aches, pains and discomforts. She would then scan her body for other 'symptoms', often quickly reaching the conclusion that she had a major illness such as cancer. Attempts to counter this thinking via thought records proved unsuccessful, partly because the threat of cancer is a long-term one and so not easy to disconfirm. At this point, the therapist reflected on the way he himself handled this type of early morning feeling and suggested that Sally could try an experiment, during which she would merely 'notice' such symptoms on waking and postpone any serious evaluation of them until 10 am. Sally accepted the rationale for this manoeuvre: that if the aches and pains were only passing phenomena, they might well have gone by that time. This proved a revelation in that not only had such aches all but gone by that time but also on rare occasions when they did persist they were less serious and intrusive.

This relatively informal approach to attentional processes has been greatly supplemented in more recent years by the development of more systematic treatment approaches to problems of attention. In this book, we will particularly focus on

mindfulness based cognitive therapy (MBCT) (Segal et al., 2002) and attentional training (ATT) (Wells, 2009), both discussed later in more detail. Mindfulness, drawing on the traditions of meditation and yoga, has developed ways of helping people view life experiences in less driven and more mindful ways. Attentional training has developed systematic ways of helping clients to shift their focus of attention while they are having negative experiences.

## THE DEVELOPING MODEL OF THE THERAPY PROCESS

The scope of CBT is ever widening, both in terms of its application to an increasing number of difficulties and in terms of a wider use of therapeutic interventions within its overall structure. In this new scenario, the concept of 'formulation', described in detail in Chapter 3, becomes even more useful. If we think of the formulation as a map of client issues likely to be relevant in therapy, then we can see that it offers us many different points from which we may start and many different possible directions in which we may proceed. We could, for example, choose to proceed in the way of standard CBT and begin to work at the symptom level – the 'top down' approach. Increasing emphasis on working with emotions in CBT allows us to work in primary and direct ways with feeling, perhaps taking techniques from experiential therapies such as focusing (Gendlin, 1998; Greenberg, 2011). There is also a growing interest in working with emotions and imagery within a cognitive framework (Hackmann et al., 2011). Stopa (2009), for example, argues that imagery work has a special ability to access emotions and therefore is relevant to CBT, with many problem areas from anxiety symptoms to schema-focused issues. Beck & Emery (1985) described using imagery as a way of understanding the meaning that the client attributes to images or dreams, and also how reprocessing images can result in the development of more functional imagery.

As new ways of working in CBT evolve, rather than always starting with NATs, options to start elsewhere (e.g., with behaviours or emotions or at the deeper level of assumptions, core beliefs and schema) open out. Deeper cognitions may be less conscious than more surface-level NATs, so that this type of CBT may bear more resemblance to psychodynamic or emotion-focused therapies. The more explorative style of the schema-focused (Young et al., 2003) and 'constructivist' (Liotti, 2007) approaches put more emphasis on taking a developmental history and spending time working at that level. Assessment in CBT may now include more emphasis on historical and developmental analysis, allowing for more exploration of the origins of the client's core beliefs and schemas. This trend also allows many clients to tell their stories from the beginning, giving a bottom-up historical perspective on their difficulties.

In newer versions of CBT events in the therapeutic relationship may be used as markers, for both client and therapist, of unhelpful patterns that may be frequent outside therapy. Safran and Muran (2000) and Liotti (2007) have used ideas from

both experiential and psychodynamic therapy to build cognitive-interpersonal perspectives for working with the therapeutic relationship. For example, if a client has had a poor attachment experience, then they may develop a core belief that 'people are not trustworthy'. They may carry that belief with them into therapy and 'incidents' may happen in which mistrust in the therapist will occur. In a similar way behaviour therapists have also stressed interpersonal processes – in this case related to interpersonal reinforcement (Tsai et al., 2009) and 'disciplined personal involvement' (McCullough, 2000, 2006) – that can be consciously used to enhance therapy.

Incidents when interpersonal issues surface offer golden opportunities to highlight the client's immediate 'hot' thoughts and schemas. Therapists can use the skill of immediacy to work with what is there in the room (Wills, 2008a) and interpersonal tangles resulting from such schemas can be worked through in the relative safety of the therapy setting, for example by what Young et al. (2003) call 'limited re-parenting'. New interpersonal behaviours can then be practiced in therapy sessions before being tried out 'for real' in the client's social environment.

**CASE STUDY**
**Mary**

Mary could see the origin of her 'people pleasing' and how it was driven by a lack of self-validation and self-esteem. She also identified an unhelpful assumption that 'I must work harder and harder to please people if I am ever to get respect and recognition'. Her people-pleasing style was sometimes active in therapy when she showed behaviour designed to 'please' the therapist. The therapist's supervisor advised him to look at how Mary could be more playful, first with her therapist and then with her colleagues. By saying things like 'I bet I really get up your nose sometimes', she could express empathy for others and, at the same time, get useful feedback from them. Mary's pattern was so ingrained that it took time for her to dare to experiment with being 'playful'. Yet eventually she did begin to get experiential and emotional disconfirmation of her belief. One day she refused to clear up the office. She sought feedback from a colleague by asking: 'I bet that surprised you, didn't it?' The colleague laughed and said that people would respect her more if she surprised them more often.

## THE 'THIRD WAVE' IN CBT: THE NATURE OF CHANGE AND THE STANCE OF THE THERAPIST

It has been hypothesised that a 'third wave' of CBT has developed over the last decade or so, following on from the first, behavioural wave in the 1950s and 60s and the second, cognitive wave in the 1970s and 80s (Hayes et al., 2004). This has developed from clinicians questioning basic assumptions of previous CBT models:

Is change always a good thing? Is doing always better than being? Newer CBT models are developing methods based on acceptance to help clients to move between acceptance and change rather than automatically aiming for change. They are more likely to use experiential strategies, encouraging broader and more flexible client repertoires. There is more emphasis on therapists' interpersonal issues as well as those of clients. This wave is open to older traditions of mindfulness, spirituality, personal values and relationships (Teasdale, 2004). One intriguing issue is the slightly counter-intuitive role that a revitalised behavioural perspective plays in the new perspective. What does this mean in practice?

Hayes et al. (1999) have pointed out that although many people believe that they can 'get better' by changing negative patterns of thought and behaviour, these patterns are remarkably persistent and seem at times to defy rational analysis and treatment. CBT has perhaps had a default position of being overly rational in its treatment objectives, assuming that the client will want to take on board a therapy and model of change that makes so much sense to therapists. Clients may have considerable 'sunk costs' already invested in their old strategies and may even expect that therapists will design strategies that will confirm or at least be compatible with their own (Leahy, 2001). They may hope that significant others can be persuaded to do things their way and so may not be looking for a strategy based on them as active agents. Sometimes old patterns are based on lack of acceptance of problems, perhaps concealed by blaming another or in over-ambitious plans to transcend difficulties. Clients may not fully realise that change is hard work and takes a great deal of commitment. If CBT is undertaken in this spirit, it is likely to founder. Thus Hayes and colleagues (1999) have termed their approach to CBT 'acceptance and commitment therapy' (ACT). This approach demands subtle shifts in the role of therapists, including ensuring that both acceptance and commitment are tackled first before engaging in the more problem-centred and active aspects of CBT.

**CASE STUDY**
**Don**

Don came into therapy secretly resenting his partner's injunction that the only way he could save their relationship was to become a 'new man'. In the event, however, no matter how sensitive or how much of a 'new man' he tried to make himself, he could not succeed in making her want him back. Therapy had been subverted into a new version of the way he had always tried to 'win her back' before. Working on his patterns of thinking, feeling and doing *were* potentially helpful to him, and yet the goal for such work had been hijacked by his old pattern. When his therapist eventually realised that this 'putting on an identity' was not a productive strategy, it was difficult to convey this to him. It was only when Don discovered that his partner was having an affair, from even before therapy, that fury released him from this nonsensical strategy and he moved quickly thereafter towards psychological health and a new, much happier relationship.

Hayes et al. (1999) suggest that therapists who are over-reliant on rational change processes could develop a more nuanced understanding of irrational factors that can influence change. Therapists need strategies that help clients to fully accept their problems and to commit to experimentation with new styles of being. ACT therapists maintain that tracks leading to change are mined with behavioural and language traps and suggest many helpful ways of defusing such impediments throughout therapy.

A further aspect of the 'third wave' is the integration of mindfulness into CBT, not only in the form of explicit mindfulness practices such as those taught in MBCT (Segal et al., 2002), but in more mindful ways of conducting therapy. The complex relationship between acceptance, mindfulness and change is well conceptualised in dialectical behaviour therapy (DBT) for people with severe, long-term difficulties. DBT aims to teach people to examine, accept and change patterns of thought and behaviour using meditation and acceptance strategies in order to stay with, and sooth bad feelings and make informed choices about change (Linehan, 1993). MBCT is described in Chapter 8.

The full implications of these more strategic ways of thinking about CBT are still being worked through and embedded in the model. They suggest to us, however, a new angle on an old chestnut. How do we keep the clarity of the cognitive and behavioural models and yet at the same time make them flexible enough to be adapted to the differing needs of individual clients? The concepts of acceptance, commitment and mindfulness can help us to develop answers for questions long suggested for initial assessment interview (Wills, 2008a):

- What is/are your exact goal/s at this time?
- What other solutions have you tried with this problem?
- How hopeful are you that therapy can help you at this time?

## CONCLUSION

Now almost 50 years old, CBT is no longer the 'new kid on the block' but is a well-established model of psychological therapy. It continues to show great vibrancy and a capacity to develop in sometimes surprising ways. CB therapists, but especially perhaps 'Beck and his group' (Wills, 2009), have always shown a capacity to listen to criticisms, and to change where appropriate. Although constructivist, schema-focused and attention-related models of CBT seem to have many differences from the original model, they also carry much of the older paradigm with them. For example, it is indeed debatable whether a true reading of Beck's earlier works does sustain the later accusations of being over-rational (Weishaar, 1993; Wills, 2009). It is probably more accurate to see the different ways of working as being on a continuum. Rather than replacing the old, newer approaches represent extensions

of the original model that allow CBT to tackle a broader range of problems. The newer models have been put forward as being particularly appropriate for those difficulties with which the older model was not so successful – especially when clients have more intransigent anxiety problems, disrupted and traumatic histories and more fundamental personality issues rather than supposedly straightforward emotional disorders. It would be easy to get carried away by the excitement of the new, and dive headlong into the third wave, as if, as Paul Gilbert (personal communication) has put it, there was something terribly wrong with the first two. New developments are still consolidating and we look forward to their greater elaboration and secure location within the cognitive behavioural therapies. One particular challenge to the CBT community will come from the desirability of maintaining the relatively simple clearness and parsimony of the original model as it integrates new developments described above. We seek to respond to this challenge in this book. In the next chapters, we look at the core and well-established features of CBT: formulation and the therapeutic relationship.

**FURTHER READING**

**The history and origins of CBT**

Beck, A. T. (1976/1989) *Cognitive Therapy and the Emotional Disorders*. New York: Penguin.
Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979) *Cognitive Therapy of Depression*. New York: Guilford Press.
Rachman, S. (1997) The evolution of CBT. In D. M. Clark & C. Fairburn (Eds), *The Science and Practice of CBT* (pp. 3–26). Oxford: Oxford University Press.

**New developments in CBT**

Hayes, S. C., Follette, V. M., & Linehan, M. M. (2004) *Mindfulness and Acceptance: Expanding the Cognitive-behavioural Tradition*, New York: Guilford Press.
Crane, R. (2009) *Mindfulness-based Cognitive Therapy: Distinctive Features*. London: Routledge.
Wells, A. (2009) *Metacognitive Therapy for Anxiety and Depression*. Chichester: Wiley.

**NOTES**

1 One 'rule of thumb' is that the original score should have at least halved and have remained at that level for 2 or 3 months.
2 'Relatively' is a key word here – see later discussion in later chapters.

# 2

# The Therapeutic Relationship and Interpersonal Sensitivity in CBT

> The CBASP (Cognitive Behavioural Analysis System of Psychotherapy) therapist must become a comrade to the patient … Comrades are authentic people who are willing to interact on a reciprocal basis in ways that stand in explicit contrast to those of negative significant others. (McCullough, 2006: 47)

A main criticism of CBT from other therapeutic perspectives is that CB therapists pay little, if any, attention to the cornerstone of other therapies, the therapeutic relationship. Person-centred therapists view CBT approaches as being overly concerned with technique and method without taking into account the primacy of the relationship. Psychodynamic therapists dismiss CBT as not using the most important therapeutic tools of their trade, the transference and counter-transference in the therapeutic relationship (Persons et al., 1996). Somehow, many older writings on CBT give the impression that the therapeutic relationship is a mere container in which to do the real work, viewing difficulties and issues in the relationship as problems to be solved before getting on with therapy. The therapeutic relationship has been notable by its absence, at times seemingly dismissed.

These views are increasingly anachronistic and the idea that CBT does not pay attention to the therapeutic relationship may now be regarded as myth (Gilbert & Leahy, 2007; Wills, 2008a). Throughout psychotherapy, regardless of model or method, clinicians see therapy as an interpersonal and emotional endeavour, a far cry from the idea which some manualised forms of therapy might give of what Norcross describes as 'disembodied therapists performing procedures on Axis I disorders' (2002, p. 4). The development of therapy in general has provided many useful ideas that help us to understand the underlying processes of therapeutic change within the therapeutic relationship, processes that are now being actively integrated into CBT. As a result, there is a growing cognitive-behavioural model of the interpersonal

process connected to the therapeutic relationship as well as a substantial focus on how to use the relationship as an active ingredient in therapy. Up until now, CBT authors have mainly focused on the role of the therapy relationship in working with 'personality disorders' and 'schema-driven problems', where the client's transference, the therapist's counter-transference and the experience of impasse in the therapeutic process all provide invaluable information for the facilitation of therapeutic movement. We will, however, argue that relationship issues can also be helpfully used to develop a more vibrant and emotionally engaged practice model for all CBT.

In this chapter, we examine how the therapeutic relationship has been viewed in the past, and how recent work on CBT has brought the therapeutic relationship more centre-stage. We describe how to build and develop collaborative relationships in CBT, and the similarities and differences between collaboration and other types of therapeutic relationship. We look at how clients' difficulties can be formulated to guide interpersonal exchanges in the relationship. We examine the problems that can occur in the relationship and ways of repairing therapeutic difficulties or ruptures.

Debates about the therapeutic relationship can be frustrating because it is often hard to get beyond clichés. Actually, the root meaning of the word 'therapy' is 'healing', so to say that there should be a 'healing' relationship in the endeavour of 'healing' people hardly gets us much further. Disagreements about the therapeutic relationship are often about different ideas of what makes for healing relationships, so that when critics say that CBT does not have a model of the therapeutic relationship they seem to mean that it does not have *their kind of* model. It may therefore be helpful to distinguish elements of the therapeutic relationship that are *involved in healing* and those that are *consciously healing in themselves* (Wills, 2012c). To get beyond clichés we must look more deeply at *how* therapeutic and interpersonal factors can be woven more fully into CBT, and hence how to enhance benefits that come from adding 'interpersonal sensitivity' into CBT (Wills, 2008a, 2009).

## WHAT DOES CBT SAY ABOUT THE THERAPEUTIC RELATIONSHIP?

Traditionally, and in contrast to other approaches, the task of CBT has been defined as resolving the client's problems, as far as possible, using the tools of CBT rather than by using the therapeutic relationship per se. A good relationship had to be in place in order to do the work, and was seen as *necessary but not sufficient* for therapeutic change (Beck et al., 1979; Persons, 2008). The technical aspects of CBT have been considered its active ingredients. If the therapeutic relationship were a car, CB therapists would use it to travel from A to B, whereas psychodynamic or Rogerian therapists would be collectors, spending hours polishing and fine-tuning the vehicle. For many clients, particularly those whose problems are amenable to short-term