COGNITIVE THERAPY *in* CLINICAL PRACTICE

AN ILLUSTRATIVE CASEBOOK

Edited by
Jan Scott
J. Mark G. Williams
& Aaron T. Beck

Foreword by Aaron T. Beck

ROUTLEDGE

Cognitive therapy in clinical practice

Cognitive therapy is perhaps best known as one of the most effective methods for treating depression. Its applications, however, are much broader and it is being applied in an increasingly wide range of clinical situations: for example with anxious, hypochondriacal, or obsessional patients, with clients who have eating problems, with drug abusers and suicidal patients, and to overcome the psychological distress that may accompany physical ill health.

The contributors to *Cognitive Therapy in Clinical Practice* discuss the use of cognitive therapy in these and other contexts, giving examples of how cognitive therapists working with different groups of clients have applied the cognitive model in their field. They combine an overview of the current status of cognitive therapy in their domain with case studies that demonstrate its particular applications. Extracts from therapy sessions are given, enabling the reader to 'hear the voices' of the patients described, to empathise with their problems, and to get alongside the therapists as they seek to build a collaborative relationship with the clients.

Of interest to a wide range of students and practitioners in clinical psychology, behavioural psychotherapy, and psychiatry, the book should do much to stimulate therapists to try out the systematic application of cognitive techniques to an even wider range of client groups.

Cognitive therapy in clinical practice

An illustrative casebook

Edited by Jan Scott, J.Mark G.Williams, and Aaron T.Beck

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Foreword

Aaron T.Beck

The success in cognitive therapy in treating a range of depressive disorders and in reducing the risk of relapse (Blackburn *et al.* 1987; Simons *et al.* 1986) has encouraged its application to clinical problems other than depression. This wider application is consistent with the cognitive model which, from the outset, was not intended to be confined to depression, but was applied to other behavioural and emotional disorders (Beck 1976; Beck *et al.* 1985). In many situations, people are subject to external events or bodily symptoms in which differences in cognitive interpretations lead to different patterns and intensity of affect and behaviour.

The extension of any therapeutic practice to a new problem area has to be taken in stages. Success in treating single cases is an essential first step. It allows us to say that a therapeutic strategy can sometimes work with this problem area. The addition of more single cases (a clinical series) will, if they also respond well, add plausibility to the claim that initial successes were not merely chance results. This is how all new therapy applications have had to start.

The efficacy of a therapy for a certain client group will ultimately be judged by a full outcome study in which a large number of similarly diagnosed patients are randomly assigned to groups, carefully assessed, and compared to patients in control conditions. But outcome studies are very expensive in time and money and cannot therefore be justified until there is a good prima facie case that a treatment will work.

The different problem areas discussed in the chapters in this book all broadly come into this initial stage, where the plausibility of applying cognitive therapy to new client groups is examined. We believe strongly that the cognitive model is relevant to these disorders and we need to listen carefully to experienced cognitive therapists to learn which aspects of cognitive therapy they have found most helpful.

The result is a volume containing examples of how cognitive therapists working in different settings with different groups of adult clients have applied the cognitive model in their domain. We have encouraged the authors to illustrate the way they work by using extended case material and to present frankly the difficulties of working with their clients. This they have done admirably, and readers will soon find themselves hearing the voices of the patients described, empathising with their problems, and getting alongside the therapists as they seek to build a collaborative relationship with the clients. Detailed consideration of case material of the sort we present in this book will always have a place in the teaching of therapeutic methods. Any psychotherapist, no matter how experienced, knows there is always more to learn about how to deal with the problems of their clients. One way of doing so is to hear cases presented by other therapists. This volume allows others to 'listen' to the cases we have presented.

In the first chapter, Ivy Blackburn discusses the problem of applying cognitive therapy (CT) to severely depressed in-patients. Blackburn's work in testing the efficacy of CT for depressed out-patients and GP patients is well known (Blackburn *et al.* 1981; Blackburn *et al.* 1987). It was the first test of CT efficacy outside of North America. But as she points out in her chapter, most outcome trials have used mild to moderately severe patients, the type of patients who are normally treated by GPs or as out-patients. In-patients are likely to have special problems, their symptoms being more extensive, severe, and disabling. Application of CT to this group has not only the difficulty of the patients' symptoms, but also of the ward milieu which is very different from the environment of the out-patient, and leads to different expectations in the patients.

The description of the patient Blackburn presents suggests that this person would have been excluded from outcome studies published to date because of the presence of psychotic symptoms. (The patient believed people were following her, that detectives were watching her. Colleagues at work, she thought, were disguised in order to watch her. She thought one of the nurses on the ward was a policewoman.) Assessment and cognitive formulation needed to be done with great care. Assessment took place over two sessions. No mention of cognitive therapy was made during session one and was held back in session two until the therapist felt that the patient was familiar with the style of cognitive therapy. The vocabulary of the therapist and the nature of the questions asked implicitly reflected the cognitive model, but the model was only explicitly produced when a good example presented itself in the normal course of therapy.

Therapy sessions were scheduled frequently during the 8-week admission. At times this was on a daily basis, and there was a total of twentysix sessions while the patient was in hospital. No medication was used for the patient throughout her

admission. Therapy continued on an out-patient basis for twice a week at the outset and for once a week for a further fifteen appointments. Despite the greater time commitment than is usually the case for out-patient depressives, if the outcome with severely depressed patients is as successful as with this patient, and if there is a reduced risk of relapse, cognitive therapy will have brought about a major improvement in quality of life for these patients as well as releasing further resources to help others.

In Chapter 2, Ruth Greenberg describes the way the cognitive model has been applied to patients with panic disorder and agoraphobia, who characteristically make catastrophic misinterpretations of bodily symptoms or mental experiences. The way these patients have difficulty in identifying thoughts as erroneous inferences, rather than as reality, is different from that often met in depression. For many depressed patients, thoughts such as 'I'm a failure' seem true (even within the therapy session). The result is that the patient finds it very difficult to see it as an 'idea' to be tested out. But many anxious patients *realise* when non-anxious (e.g. in a therapy session) that their thoughts are not realistic. Their problem is that when they next experience symptoms, this knowledge generally does not help. They will still believe, *at that moment,* that they are going to faint, go crazy, die, or lose control.

Greenberg shows how this problem can be overcome partly by persistent 'stripping away' of thoughts, images, and assumptions about being out of control; partly by behavioural experiments within the session (such as hyperventilation); and partly by identifying the core dysfunctional beliefs: their origin, development, and validity for the present. Greenberg's case example shows these procedures in action. One can see clearly, in her description of therapy, how at many points a psychodynamic therapist might have wished the course of therapy to proceed along other lines. But we also see how Greenberg's gentle but persistent investigation using the cognitive framework gains relatively quick access to some core issues for the patient (regarding his relationship with his mother) about which he was barely conscious prior to therapy.

The influence of early experience in setting up rigidly held beliefs is well illustrated in the case of an obsessional patient described by Paul Salkovskis in Chapter 3. This particular application of the cognitive model to obsessions and compulsions has been developed by Salkovskis in earlier papers (1985). The central aspect of Salkovskis's theory is that intrusive thoughts may be positive, negative, or neutral, depending on the evaluation made by the individual experiencing them. Because it is the evaluation/appraisal of intrusive thoughts by the individual which is responsible for their acquiring emotional properties, the aversiveness of mildly negative thoughts can be exacerbated by such appraisal processes. For example, while many people may have thoughts about not leaving sharp knives around the house when children are about, some individuals will appraise this thought very negatively. They will ruminate about the most negative possible consquences, worry about their own responsibility, or tell themselves what an awful person they are to be having such thoughts. Cognitive therapy is useful not only in facilitating behavioural approaches (assessment, preventing drop-outs, improving compliance, maximising effectiveness of exposure and response prevention), but also as a treatment in its own right, especially for people who fail to respond to behavioural methods.

Once again there is a need to concentrate a great deal of care and attention to the setting up of therapy in the initial sessions (compare Blackburn's similar comments). Engaging the obsessional patient is not easy and Salkovskis provides valuable hints on how best to achieve this. He does not push the patient to talk of their troubling thoughts. Rapport is established by discussing more peripheral issues. He illustrates an important advantage of the cognitive model—that a patient's poor motivation to comply with therapy can itself be analysed in cognitive terms. Until the relationship between therapist and patient is truly collaborative, little progress will be made on the central processes maintaining the disorder.

Cognitive treatment of panic disorder (Chapter 2) and of obsessional patients (Chapter 3) raises the issue of the relationship between intrusive thoughts that are normal and those that are abnormal and how their appraisal affects mood and behaviour. This is central also to clients suffering hypochondriasis and illness phobia described in Chapter 4 by Hilary Warwick and Paul Salkovskis. These authors focus on three main mechanisms that combine to increase anxious preoccupation with illness and misinterpretation of (often normal) variation in bodily functions: increased physiological arousal; selective attention to bodily sensations or appearance; behaviour aimed at avoiding stimuli associated with illness or at 'neutralising' the anxiety. Once again, the cognitive aspect of such avoidant behaviour is seen as a central factor in maintaining the disorder. Reassuring these patients does not help and it may even contribute to the maintenance of the disorder. How to proceed to engage the hypochondriacal patient in therapy without bland reassurance or combative argument about the origin of their symptoms is a major concern of Warwick and Salkovskis's chapter. The patient's own view of their problems is not directly challenged. Rather, a spirit of open-ended *enquiry* is fostered. Evidence is gathered. Collaboration is built up by the therapist finding some area of agreement with the patient, some issue closely connected to the distress the patient feels.

Warwick and Salkovskis illustrate engaging a patient in therapy who had an apparently unshakeable belief of permanent damage having been done to her throat by an experiment carried out while undergoing a tonsillectomy many years before. A second illustration, of treating a patient who feared she had cancer, shows the importance of not questioning the veracity of the symptoms, but rather exploring alternative explanations of them. A third case illustrates a patient who feared he had contracted AIDS. It is particularly interesting in that the patient's occupation had brought him into contact with high-risk groups. Some health professionals might therefore describe his anxiety as 'reasonable', and as unsuitable for cognitive

therapy. Far from it. Warwick and Salkovskis are able to make a point clearly which holds for cognitive therapy in general. Because the therapy explicitly deals with reality, rather than obscuring it with bland reassurance, positive self-talk, or investigation of complex psychodynamics, it has a good chance of being accepted by the patient as reasonable in their wish to get to the bottom of their symptoms.

Cognitive therapy has always been concerned with confronting reality rather than simply substituting positive for negative, distorted thinking. But what if the reality is itself *bad*? This question is confronted head on in Chapter 5. In most people's minds, few things could be worse than having cancer, and one would expect that extensive emotional disturbance would accompany such a condition. This is indeed often the case, as Jan Scott points out in this chapter. Yet depression and anxiety accompanying cancer are often either unrecognised, or, if recognised, go untreated because they are seen as a 'natural' response.

In her chapter, Jan Scott gives reasons why the emotional disturbance associated with severe physical illness deserves attention in its own right. First, treating the emotions may enhance the physical outcome. Second, the quality of the (sometimes shortened) life that is left for the patients may be considerably enhanced by working with them to gain as much control as possible over their illness: the physical pain, the loss of self-image related to disfigurement, changes in role if work has to stop, the grieving for the former 'well' self.

Scott illustrates these points with a case description of a 37-year-old woman, referred following diagnosis and treatment for carcinoma of the breast. On preliminary assessment she was hopeless, depressed, anxious, irritable, withdrawn, and restless. Her Beck Depression Inventory score was 27 (severely depressed). Scott outlines the goals of therapy: learning to recognise stress-provoking situations and thoughts; learning to cope with stress and altering maladaptive coping strategies; examining and improving social and family relationships; and reducing anxiety related to health. These goals were achieved (the Beck score fell gradually over ten sessions to very low levels) by careful monitoring of automatic thoughts and images, making underlying assumptions explicit (especially the belief that in order to be liked she should not manifest any weakness in the face of stress, and that she could not be happy unless she was independent of others).

Here we see how cognitive therapy can help patients with a severe physical illness. It may be 'understandable' to be frustrated, anxious, and sad about their disability. But depression is not mere 'sadness'. It is rather a deep emptiness, a wishing to withdraw, a not thinking *anything* is worthwhile, based on unwarranted assumptions about the world, the self, and the future. Of course, one can understand a person being profoundly sad if they have cancer; but they need not be left with the belief that it is their fault, that nobody loves them because they are unlovable, that to be weak is shameful.

In Chapter 6 Shelley Channon and Jane Wardle discuss the application of cognitive therapy to anorexia nervosa and bulimia nervosa. The treatment draws together a wide range of techniques including anxiety reduction and self-management principles as well as modification of dysfunctional attitudes. Because of the nature of eating disorders, with starving and vomiting being central features of the disorder, there is more emphasis on behavioural techniques than is the case with cognitive therapy with other problems. Through the description of a single case, Carol, Channon and Wardle take us through medical assessment, psychological assessment, devising a treatment plan and developing motivation for its implementation (especially by making the rationale of the treatment clear and explicit and by providing relevant factual information). Treatment then focuses on weight restoration, on specific aspects of eating behaviour including binge eating, and vomiting and laxative abuse where these occur. From an early point in treatment, therapists focus on identifying and modifying dysfunctional thoughts. Since these often arise in very precisely defined circumstances of eating, the therapist can set up an experiment in which a small amount of 'fattening food' (such as chocolate) is to be eaten during the therapy session. The patients then record their thoughts before the food is presented, when it is presented (before eating), during eating, and after eating. Modifying maladaptive aspects of these thoughts becomes an important factor alongside behavioural intervention.

Cognitive therapy with drug abusers poses many severe challenges for the therapist. Yet, as Stirling Moorey indicates (Chapter 7), the cognitive model has grown in popularity over the last 10 years since it appears to provide the best currently available way of integrating diverse approaches within therapy into a single rational package. As Moorey points out, cognitions stand at the interface between physiological, affective, and social process; thought, beliefs, and expectancies are all concepts which can be readily understood by the patient and other professionals.

Moorey considers a range of therapeutic strategies, placing them within the context of the physical aspects of addiction and its management. The different aspects of therapy are tackled in turn: engagement, problem definition and cue analysis, problem solving and cue modification, identifying and challenging underlying assumptions, and redefining maladaptive roles. As with cognitive therapy for obsessional and hypochrondriacal patients, the problems in engaging the client are legion. Moorey indicates the importance of trying as far as possible to mesh the therapy strategies to the individual's temperament. Without such attempts a therapeutic relationship will be much harder to establish. An important consideration here is the very complex motivations which patients have. As Moorey comments, it is not possible to talk of people being motivated or unmotivated to give up drugs. Fluctuation in commitment is normal and must be expected. Prochaska and DiClemente's (1983) cyclical model of recovery and relapse is commended as a helpful framework.

Listing advantages and disadvantages of giving up addictions may be one way to proceed, and Moorey gives examples of such procedures. The emphasis on specific description is continued throughout the subsequent therapy sessions—especially in cue analysis, but also in problem solving, modifying situational and emotional factors by monitoring thoughts during exposure, predicting high-risk situations and coping with them if they cannot be prevented. Dealing with underlying assumptions is an important aspect of reducing risk of relapse and is closely linked with an addict's self-schema.

Many of the problems found in cognitive therapy with drug abusers arise also in cognitive therapy with offenders. Amanda Cole (Chapter 8) describes how motivation for therapy may be very mixed in those who have offended. But consistent with the suggestions of Moorey in relation to drug abusers, this should not be taken to preclude therapy. She also describes behaviour within therapy similar to patterns described by Moorey: apparent predisposition to repeat the same vicious circle of (in this case) offending, despite punishment, despite confrontation, or despite insightful 'therapeutic' observation from professionals or others.

There is a need for careful analysis of the thoughts and images associated with the specific situation in which the offence has taken place, similar to the careful analysis which is done for clients with eating disorders (Chapter 6) and addictive behaviours (Chapter 7). The cognitions thus elicited are the 'raw material' for cognitive therapy. Cole shows how they can be used to formulate hypotheses, conceptualise the case, decide on the need for therapy, and determine which technique will be most appropriate. She uses imagery to elicit thoughts associated with offence situations, showing how it reveals a wide range of interpretation by the clients of their own feelings and of other people's attitudes and reactions. Thus offenders have beliefs such as 'Women wear tight jeans to turn men on' or 'The woman who pays attention when I expose myself is showing how it excites her'.

In a case description, Cole illustrates offender-therapist collaboration in analysing the problems associated with a recidivist exhibitionist, deciding on treatment strategies and implementing these by testing and modifying hypotheses. A major goal of therapy was not only to analyse and cope with the offence behaviour itself but also to cope with the client's dependency on therapy itself. He had stopped offending during previous therapy attempts, only to start again afterwards. Maintenance of treatment gains was to be a goal defined at the outset of treatment rather than left to the final few sessions.

Therapy was not a smooth progression from 'problem' to 'solution'. It is rare for clients undergoing any psychotherapy to experience a smooth recovery process, and cognitive therapy is no exception. The clinical course of recovery in any individual is variable. However, if the therapist has adopted an empirical approach at the outset, then problems will be anticipated and can aid therapy by contributing to the testing of hypotheses about the maintenance of the disorder. The case described by Amanda Cole is a good example of how such an approach *uses* the difficulties that arise in the course of therapy to enhance rather than undermine therapeutic progress.

During the course of cognitive therapy with any of the client groups discussed in this book, suicidal thoughts may arise. This is especially true in relation to depression, but the risks are also significantly increased in other disorders, particularly eating disorders and addictive behavioural patterns. Mark Williams and Jonathan Wells (Chapter 9) draw on their experience in dealing with depressed patients who are also suicidal and in counselling patients after they have attempted suicide, to describe therapy for suicidal patients. They point to the evidence which shows that depression by itself is often insufficient to produce thoughts of suicide. It is when depression combines with hopelessness and despair about the future that suicidal behaviour is most likely. Such hopelessness and despair may be associated with many different problems other than primary depression. Therapists must therefore be vigilant for expressions of hopelessness. These may be disguised beneath such comments as 'Sometimes I just don't know why I bother'.

Later in their chapter Williams and Wells describe a therapy session in which the thought 'Nothing has changed' is being evaluated. The thought that 'nothing has changed' crops up time and again in the minds of people when they are suicidal. As far as patients are concerned, it often provides all they need in the way of evidence that they may as well 'end it all'.

It is worth emphasising some other points made by Williams and Wells in their chapter. First, the importance of assessing the extent to which suicidal wishes are motivated by a desire to *communicate* something to somebody, and to what extent by a desire to *escape*. For most patients these motivations are mixed, but they are not necessarily conscious of either. Second, if expressions of hopelessness are taken to signal suicidal intent, then bringing such ideas out in the open is essential. As they indicate, there is no evidence that discussion of suicide promotes suicidal behaviour. Third, if suicidal ideas are being expressed, the therapist needs to assess the probability that the patient will act on these thoughts. Williams and Wells describe the factors that will need to be taken into account, especially assessment of the stability of the life situation and the person's impulsivity. They give details of cases to illustrate three approaches which supplement usual cognitive therapy techniques, listing reasons for living versus dying: targeting specific hopeless thoughts for reality testing; using time projection to encourage a patient to visualise some concrete future possibilities.

This overview of the clinical presentations should give the reader the flavour of each of the chapters. We hope that this will induce the reader to explore the topics in depth. We do not attempt to summarise the main themes in this Foreword or to speculate at this point on the next steps for cognitive therapy. We shall leave this job to the final chapter. This book will have

fulfilled its aim if it excites further enthusiasm for therapists to try out the systematic application of cognitive techniques with a wider range of client groups.

ATB

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Chapter one
Severely depressed in-patients

Ivy M.Blackburn

Introduction

Cognitive therapy (CT) of depression (Beck *et al.* 1979) was described as a method of treatment for out-patients with mild to moderate depressions. All published controlled studies of efficacy have so far included only out-patients, usually satisfying research diagnostic critieria for major or definite depression (Spitzer *et al.* 1978; Feighner *et al.* 1972), unipolar subtype. Seven studies have compared CT with antidepressant medication, each alone or in combination (Rush *et al.* 1977; Beck *et al.* 1979; Blackburn *et al.* 1981; Rush and Watkins 1981; Murphy *et al.* 1984; Teasdale *et al.* 1984; Beck *et al.* 1985). The results of these treatment trials have all confirmed the efficacy of CT in the treatment of depression, CT being found equivalent or superior to antidepressant medication. Other studies have compared CT with behaviour therapy in the treatment of depressed self-referred students and media-recruited depressed individuals. These studies (Shaw 1977; Taylor and Marshall 1977; Zeiss *et al.* 1979; Wilson *et al.* 1983) have found CT superior or equivalent to behaviour therapy and superior to waiting-list controls. Various other studies (e.g. McLean and Hakstian 1979; Shipley and Fazio 1973) have used behaviour therapy with a strong cognitive component in depressed out-patients or depressed students, and found cognitive behaviour therapy to be an effective treatment, superior to psychodynamic or supportive psychotherapy.

Thus, the efficacy of CT, as described by Beck *et al.* (1979), or of other types of short-term therapies which are primarily cognitive in orientation, has been relatively well established in the treatment of depressed out-patients. Questions which are often posed are: 'How effective is the same treatment method in the more severely depressed in-patients?' and 'Can cognitive therapy be applied to in-patients?' There are, unfortunately, no published studies to date which could begin to answer these questions, but they are undoubtedly important practical questions. In this chapter, I will discuss some of the problems involved in the treatment of severely depressed in-patients and describe a case study as illustration.

Cognitive therapy with in-patients

Why do cognitive therapy with in-patients?

Since the majority of depressed patients in Britain are treated primarily by their general practitioners and, secondly, as out-patients in psychiatric clinics (Goldberg and Huxley 1980), depressed patients who become in-patients have specific characteristics which distinguish them from the majority of depressed patients. In general, depressed patients who become in-patients in the National Health Service may have one or several of the following characteristics: psychotic features, that is delusions and hallucinations; high suicidal risk and/or suicidal behaviour; severe impairment with gross retardation or agitation, anorexia, and sleep disturbance; the need for electroconvulsive therapy (ECT) because of past history of response to ECT or because of current severity of illness; failure to respond to out-patient treatment and long duration of index episode of illness.

Severely depressed in-patients are almost invariably treated by physical methods of treatment, medication, and/or ECT, with little or no psychotherapeutic input. There are, however, several arguments for the usefulness of a psychotherapeutic approach such as CT in these patients because of, rather than in spite of, the chronic and severe illness characteristics described above.

1. Depressed in-patients may often exhibit hopelessness regarding their prospect for improvement. They are likely to have been depressed for a long time and to have already been treated with two or three different antidepressant drugs. They may have, naturally, become sceptical about outcome of further treatment. CT offers an alternative approach which has face

validity and may revive some hope in treatment in general. CT techniques can also be used to increase compliance with drug regimens when a combined treatment is being considered.

2. The long months of illness or the recurrent nature of the illness, in addition to fostering hopelessness, also creates a sense of lack of control which is increased by the medicalisation of the illness. The patient may often voice the implicit message given by the physician: 'Something is wrong with my biochemistry—there is nothing I can do about it.' By its methodology which stresses coping techniques and empirical verification, CT increases a sense of control which is in itself beneficial. A problem may arise about the apparent double or inconsistent message which is being given to the patient when he is receiving both CT and pharmacotherapy. This will be considered later in this chapter.
3. Many behavioural problems accompany severe depressive illness,either as primary symptoms of depression or secondary to the chronic nature of the illness. These are inactivity, apathy, increased dependence, lack of self-assertion and indecision. Such problems can be dealt with effectively through cognitive and behavioural methods of treatment.
4. The alternative of introducing depressed in-patients to CT after the treatment of their acute episode with physical methods of treatment may decrease the credibility of the therapy as a method of treatment for depression. The patient, who is already nearly recovered, is likely to be less involved in the treatment and less motivated to comply with the tasks which are an integral part of the therapy.
5. The promising results on the effectiveness of CT in the prevention of relapse (Simons *et al.* 1986; Blackburn, *et al.* 1987) may indicate that CT, at least as an adjunct to pharmacotherapy, is essential for depressed in-patients who have a history of frequent relapses. CT, in these cases, is often best considered as an additional treatment, in combination with medication, but, in my experience, it can also be effective on its own.

Specific problems relating to cognitive therapy with in-patients

Besides the general difficulties encountered in doing CT with severely depressed patients, the ward setting itself imposes constraints and conditions which are not operative in the case of out-patients. First of all, the environment is very restricted in terms of whom the patient interacts with, in terms of potential activities which are available, and in terms of expectations from staff and relatives and of the demands which are consequently put upon the individual. Second, hospital units and wards, in particular in a teaching hospital, are staffed by multidisciplinary teams within which widely different orientations are often represented. Unless good liaison is established, the patient may become totally disoriented. For example, the patient may be expected to attend psychodynamically oriented group therapy in the morning, have 1 hour of CT in the afternoon, talk to ward nurses who may take an excessively supportive role, be interviewed by medical students for teaching purposes, and take medication before going to bed if a combined treatment is being administered. The therapist in charge of the cognitive treatment must, therefore, be in constant liaison with the rest of the staff to inform them about the current stage of therapy and the problems which are being discussed and to get feedback in turn about ward behaviour or other problems. For example, the therapist should attend daily ward staff meetings to discuss the events of the previous day, set common goals, ensure a consistency of approach, and set a certain degree of demarcation for the role of different staff members who are involved with the patient. Third, a necessary deviation from standard out-patient practice is the setting of more frequent appointments. In my experience, daily sessions are indicated at the beginning of the therapy, even if they are short (half-hour) sessions. This is particularly important if the patient is receiving only CT, as otherwise that person might feel that not enough care or attention is being given relative to patients who receive regular medication.

Finally, although the explanation which is given to an in-patient regarding CT does not differ from that given to an out-patient, this requires particular care in the case of patients who may have been treated with only antidepressant medication for a long time before coming into hospital or who may, indeed, be continuing on a different or higher dose of medication while in hospital. Different rationales are called for if a switch from drugs to CT is being offered, or if both treatments in combination are proposed. In the former case, the risks are that patients feel desperate and see CT as the end of the road—'If this fails nothing else will work'; or they may feel angry and think that their time has been wasted so far, that they 'should have been given cognitive therapy before'. A helpful introduction to CT in such a case, after an initial interview for suitability (see later), may be: 'Mrs Smith, now that you are here in hospital, we can perhaps think of an alternative treatment approach. You have been taking these tablets for a little while now and, though they have helped a bit, there is still some way to go. We could try one of several other types of medication. However, it may be useful to take a rest from pills at this point and try a different treatment which does not involve taking medication. The treatment I have in mind is cognitive therapy. It involves talking about problems and learning some new skills to cope with them. If this treatment does not suit you after we've tried it for a little while, we will think of alternatives. Does that sound OK with you?' The therapist would then continue in the manner recommended by Beck *et al.* (1979:72–4) to explain CT and socialise the patient to CT.

When a combined treatment is being envisaged, the introduction may be: 'Mrs Smith, now that you are here in hospital, we can see whether discussing your problems on a regular basis and learning ways to deal with them, as well as continuing to take the tablets, may help you better. There are many reasons why people become depressed and often we are not sure what

these are for each individual. Sometimes, medication alone can help, but sometimes we find that combining medication with a therapy that helps people to work on their problems can be more helpful. Both treatments are equally important and work together. Let me tell you about cognitive therapy….' And again the usual explanation and socialisation would then ensue.

The following case study will try and elucidate these points further, as well as describe the course of therapy.

Case example (Anne)

Short case history and presentation

Anne was a 58-year-old single woman who was admitted to hospital after a referral by her general practitioner. Her *presenting complaint* was 'people talking about my secret affair with a gentleman'; 'people following me'; 'CID people watching me'; 'disappointed in and suspicious of everybody'. She had felt depressed and suspicious for a year, having been passed over at work for promotion to a higher rank among the office secretaries. She was having difficulties learning new computing skills and felt that the other typists thought her 'lazy' and ignored or shouted at her. Her suspicions had worsened over the last two or three weeks. She thought that people at work were people in disguise in order to watch her and that one of the nurses on the ward was a policewoman. She also complained of a flat mood, being unable to feel and to cry. She looked depressed and agitated.

On *mental state* examination, she reported sleep disturbance with early, middle, and late insomnia, low mood, guilt, inability to concentrate, loss of interest, somatic and psychic anxiety, loss of appetite, loss of weight, loss of energy and fatigability (score of 27 on the seventeen-item Hamilton Rating Scale for Depression, HRSD, Hamilton 1960). When the research diagnostic criteria (RDC, Spitzer *et al.* 1978) were checked after a diagnostic interview on the Present State Examination (PSE, Wing *et al.* 1974), the diagnosis was Major Depressive Disorder, psychotic, endogenous, recurrent unipolar depression. A previous episode of depression, thirty years before, had been treated on an in-patient basis with ECT and sodium amytal.

Personal history was unremarkable. Anne lived with her father who was a healthy octogenarian. Her mother had died in her seventies, nine years previously, and a younger sibling had died in childhood when Anne was 10 years old. Her work history was stable; she had gone to college for secretarial training after school and had worked steadily since, her last job having been in the same office for twenty-five years. Her physical health was good and she had some good friends and a number of interests.

Ward decision: Anne was prescribed only amylobarbitone 60 mg nocte, and within three days on the ward her paranoid delusions became only intermittent and she appeared to have good insight. It was felt that with her marked improvement and the fluctuation of delusional beliefs, ECT was not indicated at the time and that she would be assessed for suitability for CT. If CT was not suitable, she would be treated with amitriptyline. The reasons for considering CT were: in addition to the pattern of endogenous symptoms and the paranoid ideas and delusions, the patient expressed a number of negative views about herself; she herself expressed a preference for psychotherapy and an unwillingness to take medication;she could participate in an on-going research project on neuroendocrine changes during recovery with different treatments, including non-pharmacological treatment.

Assessment of suitability for cognitive therapy

Two main aims were set for this first interview: to assess whether the patient used some psychological terms in describing her problems and concerns, and to arrive at a cognitive conceptualisation of the case. It is advisable to keep a broad outlook and not to focus on any one area in order to obtain a general picture at this point. I find that the first interview is a very important session both for the patient and the therapist and I will, therefore, describe this interview in some detail. This interview sets the tone for the patient and should set landmarks for the therapist.

After an introduction and enquiry about how she was feeling, the questions were targeted at finding out how Anne understood her illness and how she expressed her current concerns:

T: I would like to spend an hour with you, Anne, to talk about the things that have been bothering you, the problems that you've been having. Is this all right with you?
P: Yes. Will you be able to help me?
T: We may be able to work things out together. Let's see how it goes. You can let me know if you think it's not helping.
P: All right, I can try.
T: What has been bothering you most before you came into hospital?
P: It's all my fault. I'm to blame for everything. I don't have any confidence in myself any more. I don't want to do anything.
T: When did all this start?

Note that the therapist does not pursue further the specific points raised by the patient and does not attempt any modification technique at this point.

Anne then described how she dated her problems back to three years previously when she was off work because of a surgical operation. When she went back to the office, she found that she had more responsibility, having to learn word processing on a new machine and her boss preparing for retirement. A new person was brought in to be in charge instead of Anne.

T: How did that make you feel?
P: This shook my confidence. People would be wondering why I did not get the job. I must be inferior.
T: That's what you *thought,* but what were your *feelings,* can you remember?
P: Oh…sad and disappointed. I was still weak because of the operation. I cried a lot.

Quite early on, the therapist begins to emphasise the differentiation between thoughts and feelings and how they are connected.

T: Did this last long?
P: I got better by the summer, but I had no respect for the new boss. She would come back from her lunch at 3.45 p.m. I thought the *standards* would drop. I had to show her the way and there was a lot of friction.
T: What sort of friction?
P: It was because of the word processor. The younger girls wanted to work on it all the time. Then I was moved to a different group. I felt like a battery hen. I was uncertain. I did not know what was going to happen to me.
T: What did you think could happen to you?
P: I don't know. Why was I moved to another room after twenty-five years?
T: Did you have any idea yourself about why you were moved?
P: I was not as quick on the word processor. When I went on it, one girl used to shout at me. The other one did not speak to me.
T: What did that girl shout at you?
P: She was difficult and created a bad atmosphere. She had to be the centre of attention.
T: Did she shout anything specific?
P: She called me a 'hard-faced, frustrated old maid'.
T: How did you cope with that?
P: I don't like disagreements. It makes me feel terrible. I was trying to be loyal to the new boss, Mrs T. The girls were complaining about her to the staff office.
T: OK. Let me try and summarise what you've been telling me so far, to see whether I got all the points. You feel that things have not gone well for you since your operation three years ago. There were changes in the office, a new person was put in charge, and not you; new wordprocessing machines were brought in and you felt that the younger members of staff were getting more time than you on the machines and that they were rude to you at times. You felt sad and disappointed and you thought that other people would think that you are inferior. You also worried about the standards dropping. Is this right, Anne?
P: Yes, but I kept hoping things would get better.

At this stage, the points which have emerged are concerned with standards, pride in job, difficulty adapting to new work methods, hurt by feeling of displacement and being passed over; concern about what others think of her.

T: It's now a year later, isn't it? Did things get better?
P: Oh no! Everything went from bad to worse. Two jobs were advertised one grade up from me and I applied. There were lots of applicants; most were not even from our own department.
T: What happened?
P: I did not get the job. The interview was unfair. They kept talking about my weakest point, the word processor.
T: How did that make you *feel!*
P: Terrible disappointment.

Anne went on to describe how she was then moved to a different group in the office and, a few months later, was moved again to another group, where she had to work on the word processor without any help.

P: People must have thought: 'Why is she being moved about? She is incompetent.' I was so upset that I could not go to work for one day. I went to see my GP. I felt like my balloon had burst. I could not sleep. I had nightmares about people putting me to death. I cried all the time.
T: Did you get some help from the GP?
P: He gave me Mogadon [sleeping pills].
T: Did that help?
P: Well, I went back to work. A little later, I got a presentation from the staff for twenty-five years' service.

T: Did that make you feel good?
P: I thought they just felt sorry for me. I was on the same salary, but I felt like a junior. I was unhappy and bored. I had written to the staff officer about the word processor. He wrote back saying I could not be given special treatment.
T: Were you unhappy and bored *all the time!*

This is an attempt to test whether the patient can perceive an overgeneralisation.

P: I decided to start doing other things—I joined an evening language class and a choir.
T: Did that help?
P: A bit. I went back to the GP. He said, 'What I can't cure I must endure.' I felt so frustrated. I thought that it must be my fault.
T: We are now nearly at just a few months ago. Is that right? Did anything else happen at work?
P: More disagreements and problems. I lost faith in people. I felt sick.
T: Did you do anything about it?
P: No. I thought, 'I must be strong enough to cope on my own; I should not need pills. Because of my faith, I should have had more strength.'
T: OK, Anne, I can see that you have been having a really tough time at work. I can also see that you have been battling for a long time, on your own. Are you always so hard on yourself?
P: You know, telling you about all that happened in this way makes me think how unwell I've been for a long time and that I should have come for help sooner.
T: Have you found something else to blame yourself for there, Anne? [I *smile and Anne smiles back with full understanding of what the smile implies.*] OK, we have talked for a good hour. Let's stop here and we'll continue tomorrow. I understand that there have been other problems?
P: Yes.
T: We'll talk some more tomorrow to get a full picture and we will decide then how to proceed. If you can, I'd like you to fill in some of these forms for me. They are self-explanatory. If you have any difficulties, I'll help you with them tomorrow. *[Self-ratings were done on repeated occasions and will be reported on in a later session.]* Is there anything I've said that you are not clear about and that grated on you in some way?

Beginning of cognitive formulation of case

At this point, I have decided that it may be possible to attempt CT with this patient. My conceptualisation, which will need checking and refining in future interviews, is that Anne's depression has developed over a long time in the context of events at work: changes and displacement. She expresses a negative view of herself and blames herself for lack of 'strength' and inability to 'cope'. She also expresses a negative view of the world which she sees as 'unfair' and full of 'trouble-making' people. She appears to operate under high standards, to be demanding of herself, and possibly to need constant proof of respect and affection from others. She expresses a preference to work out problems rather than take pills and she talks about her difficulties in psychological terms. Though she complains of feeling flat emotionally, she showed a lot of emotion during the interview, crying a great deal, but also responding to slight humour from me. A beginning of rapport had been established.

Because of the severity of the case, this interview is slower than it might have been with an out-patient. No explanation of CT has been given yet and the second session to complete assessment and for history taking is to take place the next day.

Session 2 (continuation of assessment for suitability for cognitive therapy)

In this session, which was six days after admission, Anne expressed more delusional ideas than she had the previous day: 'I feel that people are out to catch me, to put me to death, to make me insane'; 'people want to put me away in prison, because I'm spreading rumours'; and 'people may be doing things to me in the night, giving me ECT'.

The events that she related in this interview coincided in time with the problems which were happening at work. She had been very involved in her church activities and suddenly found that she was being supplanted by a younger woman, as convener of a committee and as Sunday school teacher. She suspected the younger woman of being a close friend of one of the church elders who was showing favouritism by putting her in charge of many things. They had scenes and the young woman's brother had threatened her.

The therapist does not attempt any specific cognitive therapy at this stage, as this would be premature. At this stage, the therapist is still attempting to formulate the case and is content with familiarising the patient with the style of CT. Instead, a lot of empathy is shown about how bad she must have been feeling and similarities are drawn between the work and the church situation by inductive questioning.