

What are Cognitive and/or Behavioural Psychotherapies?

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Overview

Cognitive and behavioural psychotherapies are a range of therapies based on concepts and principles derived from psychological models of human emotion and behaviour. They include a wide range of treatment approaches for emotional disorders, along a continuum from structured individual psychotherapy to self-help material.

Theoretical Perspective and Terminology

Cognitive Behaviour Therapy (CBT) is one of the major orientations of psychotherapy (Roth & Fonagy, 2005) and represents a **unique** category of psychological intervention **because** it derives from cognitive and behavioural psychological models of human behaviour that include for instance, theories of normal and abnormal development, and theories of emotion and psychopathology.

Behaviour therapy, the earliest of the cognitive and behavioural psychotherapies, is based on the clinical application of extensively researched theories of behaviour, such as learning theory (in which the role of classical and operant conditioning are seen as primary). Early behavioural approaches did not directly investigate the role of cognition and cognitive processes in the development or maintenance of emotional disorders.

Cognitive therapy is based on the clinical application of the more recent, but now also extensive research into the prominent role of cognitions in the development of emotional disorders.

The term ‘Cognitive-Behavioural Therapy’ (CBT) is variously used to refer to behaviour therapy, cognitive therapy, and to therapy based on the pragmatic combination of principles of behavioural and cognitive theories.

New CBT interventions are keeping pace with developments in the academic discipline of psychology in areas such as attention, perception, reasoning, decision making etc.

What is CBT?

Cognitive and/or behavioural psychotherapies (CBP) are psychological approaches based on scientific principles and which research has shown to be effective for a wide range of problems. Clients and therapists work together, once a therapeutic alliance has been formed, to identify and understand problems in terms of the relationship between thoughts, feelings and behaviour. The approach usually focuses on difficulties in the here and now, and relies on the therapist and client developing a shared view of the individual’s problem. This then leads to identification of personalised, usually time-limited therapy goals and strategies which are continually monitored and evaluated. The treatments are inherently empowering in nature, the outcome being to focus on specific psychological and practical skills (e.g. in reflecting on and exploring the meaning attributed to events and situations and re-evaluation of those meanings) aimed at enabling the client to tackle their problems by harnessing their own resources. The acquisition and utilisation of such skills is seen as the main goal, and the active component in promoting

change with an emphasis on putting what has been learned into practice between sessions (“homework”). Thus the overall aim is for the individual to attribute improvement in their problems to their own efforts, in collaboration with the psychotherapist.

Cognitive and/or behavioural psychotherapists work with individuals, families and groups. The approaches can be used to help anyone irrespective of ability, culture, race, gender or sexual preference. Cognitive and/or behavioural psychotherapies can be used on their own or in conjunction with medication, depending on the severity or nature of each client’s problem.

Titles and Levels of Practice

Cognitive and/or Behavioural Psychotherapists are usually health professionals such as specialist mental health nurses, psychologists, psychiatrists, general practitioners, social workers, counsellors or occupational therapists who have received additional cognitive and/or behavioural therapy training and supervision (see Appendix 1 for an outline of the skills required by a CBT therapist). Whilst all cognitive and behavioural psychotherapists share the above principles, individual therapists may call themselves by different titles. The title used may reflect the theoretical underpinnings of the specific therapy delivered (e.g “behaviour therapist” if therapy is based on the principles of learning theory, “cognitive therapist”, if therapy is based on the principles of a cognitive model of emotional disorders), but more often the term “cognitive behaviour therapist” is used by practitioners, referring to therapy based on either cognitive or behavioural principles, or a combination of these. The terms “psychotherapist” and “therapist” or “psychotherapy” and “therapy” are used synonymously. Whatever title they use, the approach is commonly referred to as CBT.

There are different levels of the practice of CBT, which require very different skill levels on the part of the person talking to the “client”.

1. Formulation driven CBT (individual or group CBT for a range of people and problem areas) – This is a form of psychotherapy, the clients are not able to help themselves and have sought help from a trained professional and require expert interventions from an appropriately trained and supervised CBT psychotherapist. The relationship between the therapist and the client is paramount and expert skills are required to engage the client in a therapeutic alliance. Once this is established therapy can proceed collaboratively through assessment, formulation and intervention. The therapist using various cognitive and/or behavioural techniques as appropriate. They would evaluate the efficacy of any intervention and change tack if necessary.
2. CBT approaches - Specific CBT interventions for specific problem areas (e.g. concordance training; relapse prevention work in people with a diagnosis of Schizophrenia; identification of symptoms and specific CBT intervention in post-partum depression; anger management groups, anxiety management groups, pain management etc). This is **not** a form of psychotherapy as the health workers are implementing a technical intervention, they are not required to formulate and adapt the treatment. The health workers will have received training in specified

- CBT interventions for particular problem areas, and should be receiving supervision from a CBT psychotherapist.
3. Assisted self-help (computerized CBT, self-help material presented to a support group or individuals by a health worker, such as a graduate mental health worker or assistant psychologist) – This is **not** a form of Psychotherapy and only limited, if any, formal CBT skills or training are required by the individual introducing the approach, such individuals should not be claiming that they are ‘doing’ CBT.
 4. Self-help (books, bibliotherapy) – This is **not** a form of psychotherapy and no CBT skills or training are required by the individual reading the self-help material.

Although there is some evidence for the efficacy of CBT approaches at many different levels, from now on for the purposes of this document, when the term “CBT” is used, we are referring to CBT **psychotherapy** outlined in level 1 above.

The Evidence Base for CBT

Treatment interventions are predicated on a robust evidence base derived from studies utilising randomised controlled and single-case methodologies that have demonstrated the efficacy and effectiveness of cognitive and behavioural psychotherapies in the treatment of common mental health problems, including the anxiety disorders, generalised anxiety, panic, phobias, obsessive-compulsive disorder, posttraumatic stress disorder, bulimia and depression as identified by a host of recent reviews by NICE, SIGN and other review bodies. CBT models have also been developed for use in an increasing range of mental health and health difficulties including severe and enduring mental health problems, such as psychosis, schizophrenia, bi-polar disorder, anger control, pain, adjustment to physical health problems, insomnia and organic syndromes, such as early stage dementia. There is an extensive research base around behavioural approaches in working with children and people with learning disabilities, severe and enduring mental health problems and “challenging behaviour” generally. More recently CT and CBT have become the treatments of choice for adolescent depression, and for use with children and in intellectual disability (learning disability). Research into the contribution of psychological factors to physical health problems (such as low back pain, chronic fatigue, recovery from surgery for example) is growing and has led to the development of CB approaches in these areas.

Developments in cognitive therapy, cognitive-behavioural therapy and/or behaviour therapy research, theory and practice (particularly in the development, or refinement, of clinical techniques/methods) are occurring rapidly. So are developments in cognitive and behavioural psychological perspectives of normal and abnormal psychological processes such as human development and emotion. The application of cognitive, behavioural and cognitive-behavioural theory and approaches is happening in many fields other than mental health, eg. Education and training, public health, organisational psychology, forensic psychology, management consultancy, sports psychology for instance.

Key Concepts in Cognitive-Behavioural Therapy (CBT)

The cognitive component in the cognitive-behavioural psychotherapies refers to how people think about and create meaning about situations, symptoms and events in their lives and develop beliefs about themselves, others and the world. Cognitive therapy uses techniques to help people become more aware of how they reason, and the kinds of automatic thought that spring to mind and give meaning to things.

Cognitive interventions use a style of questioning to probe for peoples' meanings and use this to stimulate alternative viewpoints or ideas. This is called 'guided discovery', and involves exploring and reflecting on the style of reasoning and thinking, and possibilities to think differently and more helpfully. On the basis of these alternatives people carry out behavioural experiments to test out the accuracy of these alternatives, and thus adopt new ways of perceiving and acting. Overall the intention is to move away from more extreme and unhelpful ways of seeing things to more helpful and balanced conclusions.

The behavioural component in the cognitive-behavioural psychotherapies refers to the way in which people respond when distressed. Responses such as avoidance, reduced activity and unhelpful behaviours can act to keep the problems going or worsen how the person feels. CBT practitioners aim to help the person feel safe enough to gradually test out their assumptions and fears and change their behaviours. For example this might include helping people to gradually face feared or avoided situations as a means to reducing anxiety and learning new behavioural skills to tackle problems.

Importantly the cognitive and behavioural psychotherapies aim to directly target distressing symptoms, reduce distress, re-evaluate thinking and promote helpful behavioural responses by offering problem-focussed skills-based treatment interventions.

Key Factors Influencing the Effective Delivery CBT

- Therapeutic relationship – a trusting, safe, therapeutic alliance is essential but not sufficient for successful CBT.
- Collaboration –
 - Is a way of being with clients based on an equal partnership, each party bringing something to the relationship. The therapist brings skills and knowledge of psychological processes, theories of emotion and techniques that have helped others and could help the current client. The client is an expert in their own experience, and brings their own resources.
 - The therapist should not have pre-conceived ideas about where the therapy is going.
 - The overall aim is for the individual to attribute improvement in their problems to their own efforts, in collaboration with the psychotherapist.
 - Therapy is not experienced as something that has been “done to” the client.
- Formulation – a unique map or hypothesis of presenting problems or situations which integrate information from assessments within a coherent CBT framework drawing upon theory and evidence based practice.
- Socratic dialogue/ guided discovery – is a style of questioning to both gently probe for people's meanings and to stimulate alternative ideas. It involves

- exploring and reflecting on styles of reasoning and thinking and possibilities to think differently. CBT is not about trying to prove a client wrong and the therapist right, or getting into unhelpful debates – rather by skillfully collaborating, clients come to see for themselves (discover) that there are alternatives
- Homework – the client tries things out in between therapy sessions, putting what has been learned into practice. This is referred to as homework and sometimes includes behavioural experiments.

CBT Compared to other Modalities and Myths about CBT:

- The cognitive and behavioural psychotherapies target problems in the here and now with much less therapeutic time devoted to experiences in early life.
- The therapeutic relationship is seen as an essential ingredient but unlike other psychotherapies is not viewed as the main vehicle of change. Instead the focus is in collaborative working on jointly agreed problems.
- The effectiveness of CBT is supported by evidence from randomised controlled trials (RCTs), uncontrolled trials, case series and case studies.
- It is both highly structured (although always based on a formulation of the relationship between the client's presenting problems and underlying cognitive and/or behavioural processes) and flexible due to the constant evaluation of the outcome of the interventions.
- Cognitive therapists do not usually interpret or seek for unconscious motivations but bring cognitions and beliefs into the current focus of attention (consciousness) and through guided discovery encourage clients to gently re-evaluate their thinking.
- It is a form of therapy that addresses problems in a direct and targeted way.
- It focuses on a shared model of understanding, using a psycho-educational approach, open sharing of the formulation and teaching of self-evaluation and management skills.
- Its potency as a model is shown by its increasing use and accumulating recommendation by a range of evidence-based guidelines.

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Drawing on papers published by BABCP or in use by the various committees of BABCP.
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Reference

Roth A., and Fonagy P. (2005) What Works for Whom: A critical review of psychotherapy research. Second Edition. The Guildford Press, London.

Appendix 1.

The process of therapy and the skills required by CBT psychotherapists:

Assessment – knowledge and understanding of a range of CBT assessments.

Formulation – to derive formulations of presenting problems or situations which integrate information from assessments within a coherent CBT framework drawing upon theory and evidence based practice.

Intervention – On the basis of the formulation the therapist will be able to implement therapy or intervention techniques appropriate to the presenting problem and to the psychological and social circumstances of the client.

Evaluation – to select and implement appropriate methods to evaluate the effectiveness, acceptability and broader impact of the interventions (both individual and organisational), and use this information to inform and shape practice.

Key skills of CBT Psychotherapists:

CBT is a research based approach to therapy:

- CBT psychotherapists must have an effective understanding of the range of cognitive, cognitive-behavioural and/or behavioural models of Human Behaviour and/or the Person.
- CBT psychotherapists must have an effective understanding of the theoretical and research-based models of individual development across the lifespan, and within the cultural and social contexts prevailing.
- CBT psychotherapists must have a good knowledge of the philosophical and theoretical bases of CBT, their practical application to various client groups and their current empirical status.
- CBT psychotherapist are able to identify and critically evaluate relevant research.
- The CBT psychotherapist should be able to justify the interventions being used with clients on the basis of research evidence.
- The process of therapy itself is based on a scientist-practitioner model. A hypothesis (formulation) is formed which leads to an intervention the results of which are then evaluated for their effectiveness. Conclusions are drawn and the hypothesis may change due to the outcome of the intervention and evaluation process. This in turn may lead to the intervention being changed.

Therapeutic skills:

- An ability to engage clients and form a collaborative working relationship with them.
- Ability to conduct a comprehensive assessment involving interview, observation, data collection and the use of relevant clinical measures.
- An ability to formulate a model of therapeutic change using theory, principles and research derived from the cognitive, cognitive-behavioural and/or behavioural approaches to therapeutic change.

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- Use educational strategies and relationship skills to inform the client/patient and encourage their active participation in clinical decision-making and the development of a personalised therapeutic programme based on cognitive and/or behavioural theoretical principles and research.
- Implement a therapeutic programme with the active participation of the client/patient, skilfully using a range of cognitive and/or behavioural methods to teach /coach them in the acquisition of improved skills in their use of more adaptive cognitive, behavioural and physiologically responsive strategies for the alleviation of distress and development of personal effectiveness.
- Monitor the effects of treatment, reinforcing and shaping the client/patients participation; modifying the treatment procedures as dictated by progress, data feedback and collaborative problem-solving.
- Skilfully utilise the clinical environment, community resources and the clients own home setting (as relevant), with the involvement of client/patient partner, family and significant others (where relevant and with the client/patients informed consent) to facilitate and generalize effective change and feedback.
- Evaluate client/patient progress through the collaborative clinical relationship, preparing them for increased independence from therapeutic help and discharging them from active treatment into a planned follow-up process that audits clinical effectiveness through client/patient outcome measures.

Professional skills:

- Skills, knowledge and ethical values to work effectively with clients from a diverse range backgrounds, understanding and respecting the impact of difference and diversity upon their lives including service and user-led systems and other elements of the wider community.
 - High level skills in managing a personal learning agenda and self-care, and in critical reflection and self-awareness that enable transfer of knowledge and skills to new settings and problems.
 - Ability to think critically, reflectively and evaluatively. To have an understanding of the supervision process and use supervision to reflect on practice.
 - Have an understanding of the applicability of CBT across a wide range of client groups.