



8

# Cognitive behavioural therapy

## ◆ Introduction

In Unit 2 we identified the major theoretical approaches to counselling, from which all the contemporary models described in this book have evolved. Of the three perspectives – psychodynamic, humanistic and behavioural – only the behavioural and the cognitive behavioural approaches remain to be discussed.

Many of the counselling models we have looked at describe the internal or unseen characteristics said to govern human behaviour. The structure of personality outlined by Freud, and the actualising tendency both Rogers and Maslow upheld, are located firmly within the person. In contrast to this, the cognitive behavioural tradition is concerned with human behaviour and thinking. The behavioural tradition, which originated before the development of cognitive behavioural therapy, stems from the work of a group of psychologists whose findings we shall briefly outline in this unit. The emphasis on observable behaviour alone, which was the hallmark of behaviour therapy, has radically shifted to incorporate the importance of cognition in determining a person's actions and behaviour. In this unit, we shall concentrate on the development and principles of cognitive behavioural therapy, which is now used widely within the NHS and by private practitioners.

### KEY TERM

**Cognition:** The experience of thinking, reasoning, perceiving and remembering. Early behaviour therapy highlighted observable behaviour only, while cognitive behaviour therapy stresses that thinking affects how we feel and what we do.

## Evolution of behaviour therapy

Behaviour therapy evolved from theories of human learning that were formulated at the beginning of the twentieth century. The first studies of learning took place in laboratories, and animals, not humans, were used in the experiments. In the following section we shall list some of the main contributors in the field of learning theory.

### Ivan Pavlov (1849–1936)

Through his work with dogs, Pavlov formulated the principle of classical conditioning (Pavlov, 1927). The dogs in Pavlov's experiments salivated at the sound of a bell, prior to eating. Eventually, the dogs were seen to salivate when they heard the bell, even when no food followed. This associative learning offers some explanation about the way humans develop phobias.

It highlights the process whereby an event, object or activity becomes associated with a specific response, usually avoidance in the case of a phobia.

## **J. B. Watson (1878–1958)**

Watson contributed to learning theory by frightening a small child who was playing with a pet rat. This was achieved by producing a loud noise each time the boy played with the animal. Eventually, the child's fear extended to all furry toys and even fur coats (Watson, 1928). Watson's work supports the view that human emotional responses, like phobias, are usually the result of conditioning. If we accept this is the case, then it seems logical to suppose that conditioning can be reversed through a process of unconditioning. Such a process is fundamental to many of the methods traditionally used in behaviour therapy.

## **E. L. Thorndike (1874–1949)**

Learning theory was furthered by Thorndike (1911), who also experimented with animals. He formulated the law of effect, which states that when a response to a specific stimulus is followed by a reward, the bond between the stimulus and the response will be strengthened. On the other hand, when the response is followed by a negative outcome, the bond will be weakened. His research enhanced the status of learning in psychology and showed that it is possible to predict behaviour through an understanding of its laws. In simple terms, we could say that a satisfying experience is one that induces movement towards it, while an unsatisfying experience has the opposite effect. Behaviour is therefore dependent on its consequences, which may be either reward or punishment.

## **B. F. Skinner (1904–1990)**

Skinner, whose work was conducted in the 1930s at the University of Minnesota, extended the research of Thorndike. Skinner's experiments on laboratory animals indicated that in order to ensure responses will be repeated, animals need to be rewarded. This, in turn, means that animal behaviour is reinforced. Skinner's laboratory animals learned by trial and error that there is a link between behaviour (pressing a lever) and the reward of food. If a certain type of behaviour leads to discomfort, however, or an expected reward is not forthcoming, then the behaviour becomes less likely in the future. According to Skinner, 'Behaviour is shaped and maintained by its consequences', a maxim which is as relevant to humans as it is to animals (Skinner, 1988: 23).

## **Albert Bandura (1925–)**

Bandura belongs to another group of psychologists, called the social learning theorists, who accept that human learning takes place according to the principles of reinforcement and punishment. However, they go beyond this and suggest that children learn from others, too, through a process of observation and imitation. Children who observe others being disciplined for certain behaviours, for example, are unlikely to engage in that behaviour themselves.

By the same token, behaviour that is clearly rewarded in others is likely to prompt imitation. The social learning theory of Albert Bandura (1977) helps to explain how people acquire complex social behaviours in social settings.

### Joseph Wolpe (1915–1997)

Wolpe, a South African psychiatrist, also contributed significantly to the field of behaviour therapy. In 1958 he developed behavioural methods that were effective in relieving a number of psychological problems, including stress, anxiety and irrational fears. He pioneered the use of systematic desensitisation, for the treatment of phobias, and the technique of progressive relaxation training, which is used in conjunction with systematic desensitisation in therapy (Wolpe, 1958).

### Hans J. Eysenck (1916–1997)

Eysenck, a psychologist who worked at the Maudsley Hospital in London, contributed to the development of behavioural therapy when he produced a study in 1952 of the effectiveness of psychoanalysis as a treatment for psychological problems. The results of the study are interesting and suggest that psychoanalysis achieved very little. These findings gave a great boost to behaviour therapy as a model for treating people with emotional problems. It also ensured that the work of clinical psychologists who used behaviour therapy techniques gained in popularity, as attention focused on the work they were doing. However, Eysenck's findings have been disputed by various theorists and practitioners over the past 50 years.

## Procedures which stem from the behavioural tradition

Behaviourism has within its repertoire a wide range of methods that can be used with clients. Some of the established behavioural techniques that are frequently used in therapy are given below.

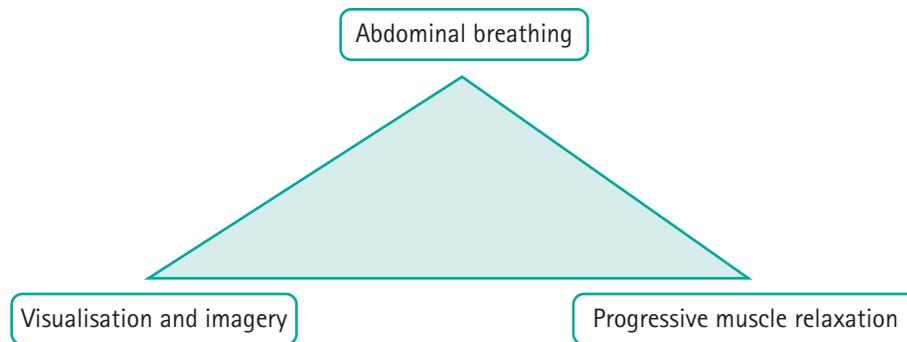
### KEY TERM

**Behaviourism:** The scientific study of behaviour based on observable actions and reactions. The focus is on analysing the relationship between behaviour and the environment, and the way that stimuli provoke responses.

### Relaxation training

Anxiety and stress are common problems for many clients who seek help. In view of this, relaxation training is used extensively for a variety of problems.

Anxiety affects people on three levels – psychological, physiological and behavioural. It tends to increase the heart and breathing rates and may cause other symptoms, including muscle tension, irritability, sleep problems and difficulty in concentrating. Many anxious people breathe in a shallow fashion from the chest. Clients can be taught to change this pattern so that deeper abdominal breathing is learned. This has the effect of increasing oxygen supply to the brain and muscles which, in turn, help to improve concentration, promote calmness and deeper connectedness between mind and body. Clients can be taught to set aside time each day for relaxation, and there are numerous instruction manuals and recordings to facilitate this practice.



**Figure 8.1** Aids to relaxation

## EXERCISE

### Relaxation

Sit quietly in a chair until you feel still and comfortable. Beginning with your feet, allow all the muscles of your body to relax. Place your hand on your abdomen and breathe in slowly and deeply through your nose. You should feel your abdomen extend as you do this. Now breathe out slowly through your mouth, noting how your abdomen returns to its usual shape. Repeat the breathing exercise for about five minutes, then sit still again and experience your relaxed state. A slight variation of the exercise is to repeat a chosen word, or phrase, each time you breathe out.

**Comment:** This simple exercise forms the basis of most relaxation techniques. To test its effectiveness, you could ask someone to take your pulse before and after the exercise. Your pulse rate should be slower afterwards, which indicates a more relaxed state.

## Systematic desensitisation

This is a technique devised by Wolpe (1958). It is used as a means of helping clients to deal with irrational fears and phobias. It is based on the premise that it is impossible for someone to be anxious and relaxed at the same time.

Since anxiety responses are learned or conditioned, it should be possible to eliminate these responses if the anxious person is helped to relax in the face of the anxiety producing stimulus. The client is, therefore, systematically desensitised to the fearful object, or situation, through a process of exposure to it, while in a relaxed state. Progressive muscle relaxation techniques and deep breathing are integral to this technique, and clients are taught how to reduce anxiety before they confront their fear. Constructing a 'hierarchy' is another important feature of systematic desensitisation and involves a series of situations or scenes relating to the phobia. Each scene in the hierarchy is ranked from mildly to extremely anxiety-provoking.

## CASE STUDY

### Constructing a hierarchy

The following is an example of a hierarchy that was used to help a 20-year-old client, called Isobel, who had a phobia about eating in front of strangers. Isobel's phobia was embarrassing and inconvenient because it meant that she refused to socialise on many occasions. The counsellor taught her the relaxation procedure and breathing method already described, and then helped her to design and work through the following hierarchy, which she was encouraged to practise on a regular basis.

Visualise:

- ◆ asking a close friend to accompany you on a visit to a restaurant
- ◆ phoning a restaurant to make a reservation
- ◆ getting dressed for your evening out
- ◆ doing your hair and putting on make-up
- ◆ opening the door to greet your friend
- ◆ walking to the restaurant, a short distance away
- ◆ meeting people along the way
- ◆ passing other cafes and restaurants as you walk along
- ◆ arriving at the door of the restaurant
- ◆ speaking to the waiter about your reservation
- ◆ walking to the table with your friend and the waiter
- ◆ placing an order with the waiter
- ◆ looking at your food when it arrives
- ◆ picking up the knife and fork and starting to eat
- ◆ tasting the food and enjoying it
- ◆ looking around at other diners
- ◆ noting that other people are enjoying themselves
- ◆ becoming aware that other people are enjoying themselves
- ◆ becoming aware that other people occasionally glance at your table
- ◆ continuing your meal and the conversation with your friend.

## CASE STUDY Cont...

**Comment:** Clients need to give a detailed history of the phobia, with special emphasis on those aspects of it which cause the most anxiety. What made this client most anxious was the thought of being observed while eating. For this reason, observation was presented towards the end of the hierarchy, which meant that Isobel could work gradually towards it.

## Assertiveness training

Clients who seek counselling often experience difficulties in three key areas. These include:

- expressing their feelings
- asking for what they need or want
- saying no to requests from others.

The most important aspect of assertiveness training is in helping clients to differentiate between submissive, aggressive and assertive styles of communication. When people are submissive they tend to ignore their own rights and needs, and this can result in feelings of depression and anger, which are never really expressed. Aggressive people may be bullying and demanding, characteristics that alienate others. On the other hand, assertive behaviour involves direct person-to-person communication without manipulation, hostility or submissiveness. Assertiveness training is widely available in groups and clients are sometimes referred to them so they can increase their self-awareness and confidence generally.

## The cognitive emphasis

As the name suggests, cognitive therapy is concerned with the thinking and reasoning aspects of a person's experience. We have seen that behaviour therapy evolved from the theories of learning first formulated by Pavlov, Watson, Thorndike, Skinner, Wolpe and Eysenck, and from the experiments of Bandura and other psychologists who were interested in the effects of observation on the individual's learning experience. The behavioural approach, widely used in the 1950s, emphasised the importance of visible behaviour and its environmental context. However, this emphasis tended to ignore the thinking and feeling aspects of human behaviour; it was not until several psychologists, including Aaron Beck and Albert Ellis, began to focus on the thoughts and beliefs of disturbed or anxious clients that the cognitive dimension came into being.

The work of these theorists highlights the way in which anxious and depressed clients contribute to their own problems through faulty, or destructive, thought processes and preoccupations. This section looks in some detail at the work of two cognitive behaviour models. The first model

was pioneered in 1955 by Albert Ellis, and the second was developed in the early 1960s by Aaron Beck.

## Albert Ellis (1913–2007)

Albert Ellis was responsible for pioneering cognitive behaviour therapy (CBT) in the 1950s; since then, his own individual approach, now called rational emotive behaviour therapy (REBT), has become one of the most popular cognitive models. Ellis, who was trained in psychoanalysis, became disillusioned with what he perceived to be its limitations. As a result of his scepticism and his doubts about ‘the efficacy of classical analytic techniques’, he found himself trying out different methods, many of which he found unsatisfactory too (Ellis, 1991: 7). Ellis, who was born in Pittsburgh, Pennsylvania, was President of the Albert Ellis Institute in New York. Until his 90s, and despite numerous health problems, he conducted regular workshops in rational emotive behaviour therapy at the Institute. His background training included studies in accounting, clinical psychology, family and marriage counselling and, of course, psychoanalysis. Classical psychoanalysis is an in-depth and time-consuming form of therapy, not suited (or available) to many clients, and Ellis was concerned to establish a more egalitarian and pragmatic approach, which would address the needs of a wider range of people seeking help (Ellis, 1991).

Albert Ellis held many posts throughout his career, including Consultant in Clinical Psychology to the New York Board of Education and Vice President of the American Academy of Psychotherapists. He also wrote numerous books and articles and served as consulting or associate editor of many professional journals.

### Development of the approach

During the 1950s Ellis became interested in behavioural learning theory. He noted that psychoanalysis and learning theory have a great deal in common, since both emphasise the importance of conditioning in early life (Ellis, 1991). However, he concluded that action as well as insight is necessary if people are to address the difficulties that stem from childhood and the early conditioning that determines so many problematic responses in adult life. In addition, Ellis identified the central place of negative thinking in the perpetuation of emotional disturbance, and he was especially interested in the type of negative thinking which reinforces early disturbing and traumatic experiences. Clients, he believed, often cling to outdated feelings of anger and guilt, which impede psychological growth, and are, in any case, no longer applicable to the present situation. Outdated or negative thinking is often the direct result of information that has been conveyed to clients at an early stage by parents or other important people at that time. In Ellis’ view, language is the key to the perpetuation of emotional problems, since it is through the use of language and ‘the

symbol-producing facility that goes with language' that clients enforce their fears and anxieties stemming from early life (Ellis, 1991: 14). To compound the problem even further, people frequently denigrate themselves and their efforts, demand perfection from themselves and others and become 'illogically upset' over the frustrations of ordinary life (Ellis, 1991: 71).

## Other influences

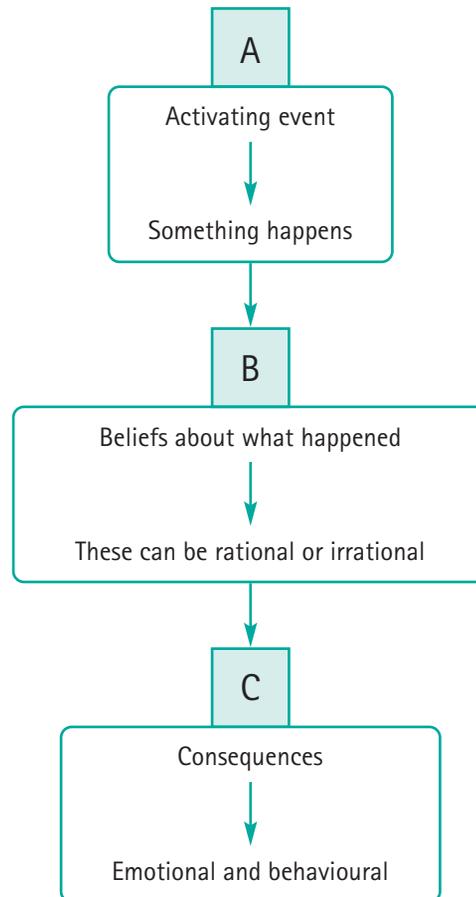
The importance of both language and thinking is stressed throughout Ellis' writing. References to philosophy and literature are also frequent and, indeed, these two subjects have informed and helped to define many aspects of his work. Ellis was especially interested in the Stoic philosophers, including Epictetus, who believed that people become disturbed, not by events themselves but by personal interpretations of those events.

## Development of the title

Ellis changed the title of his approach several times from its inception in the 1950s. The original title (rational psychotherapy) did not do full justice to the layers underpinning the theory, since it failed to incorporate the three components – cognitive, emotional and behavioural – of human experience. Ellis also wanted to differentiate between his own model and other purely cognitive approaches that were emerging in the 1950s. In 1959, two years after he abandoned psychoanalysis, he founded the Institute for Rational Emotive Therapy, now the Albert Ellis Institute. In 1993 Ellis changed the title again, this time to Rational emotive behaviour therapy (Ellis, 2005).

## The theory of rational emotive behaviour therapy

Ellis believed that many human problems are generated from three important sources. These include thinking, emotional and



**Figure 8.2** The ABC model (adapted from Ellis, 1991:176)

behavioural sources, but he placed special emphasis on the significance of 'cognition', or thinking, in the perpetuation of psychological disturbance (Ellis, 1991: 106). Ellis referred to a number of philosophers to support his thesis, and suggested that human beings create their own disturbed feelings, which they either consciously or unconsciously generate. If we accept this is the case then it follows, according to Ellis (1991), that people have within themselves the resources and willpower necessary to effect lasting and healthy change. Ellis further described the sequence of events that lead to psychological disturbance through the use of an ABC model (see Figure 8.2).

In the first instance, people start with goals in life, and these are usually constructive and positive. What tends to happen, however, is that problems and difficulties are encountered at various stages, which interfere with a person's desire for success and comfort. After this, people construct their own largely negative beliefs, or interpretations, of these events and these beliefs lead to certain emotional and behavioural consequences. According to Ellis, people are liable to believe that unless they do well in all aspects of everyday life they are 'worthless' or 'no good', attitudes which inevitably lead to feelings of failure and guilt (Ellis, 1991: 28).

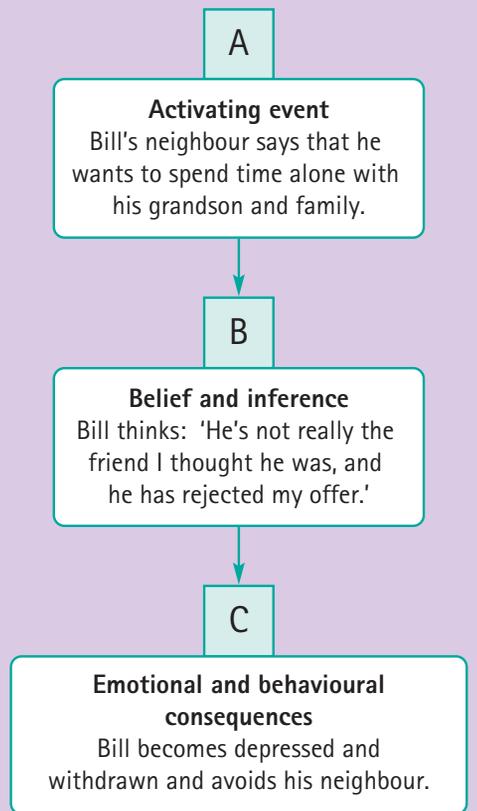
## CASE STUDY

### The ABC model

Bill, who was in his 50s, had a very good relationship with his next-door neighbour, Roy, who was about the same age. Bill applied to his doctor for counselling help because he suffered from increasing depression, linked to several significant changes in his life. His parents had died in the previous year, and he had just discovered that his daughter's marriage was breaking up. In addition to his depression, Bill suffered from severe loss of confidence, which, he said, had been prompted by his experience of early retirement and by feelings of panic about his age. During counselling Bill talked about an incident with his neighbour, Roy, which had caused him a great deal of anxiety and had knocked his confidence even further. Roy's eight-year-old grandson had come to stay for a holiday and, several days later, Bill's own grandson came to stay with him too. When Bill suggested to his neighbour that they should plan some activities together, Roy responded by saying that while he would be happy to share some time as a group, he would also like to reserve most outings with his grandson and members of his own family. Bill ruminated at length about this response, which he took as a personal rejection of himself and the friendship he offered. Afterwards he became even more depressed and withdrawn, and for several weeks avoided his neighbour. The rational emotive therapy model, see Figure 8.3, shows in diagram form this sequence of events.

## CASE STUDY Cont...

**Comment:** Ellis' ABC model of personality and emotional disturbance highlights the relationship between thinking and emotion. In Ellis' view, (Ellis, 1991) it is not what happens at point A that causes emotional disturbance or distress. People form their own inferences and beliefs at point B, and reinforce them through the use of negative and 'catastrophising' self-talk and rumination. It is this internal soliloquy which then leads to the emotional and behavioural reactions that occur at point C. Bill's action in avoiding his neighbour led to a worsening situation, since eventually Roy stopped making social overtures in the mistaken belief that Bill had lost interest. This had the effect of deepening Bill's depression and general loss of confidence. In counselling, he was helped to see how his own thinking had contributed to his problems overall. The counsellor explained the ABC model of rational emotive behaviour therapy to Bill. It should be added, however, that there were other factors in this client's life that contributed to his depression, and these were also addressed in counselling.

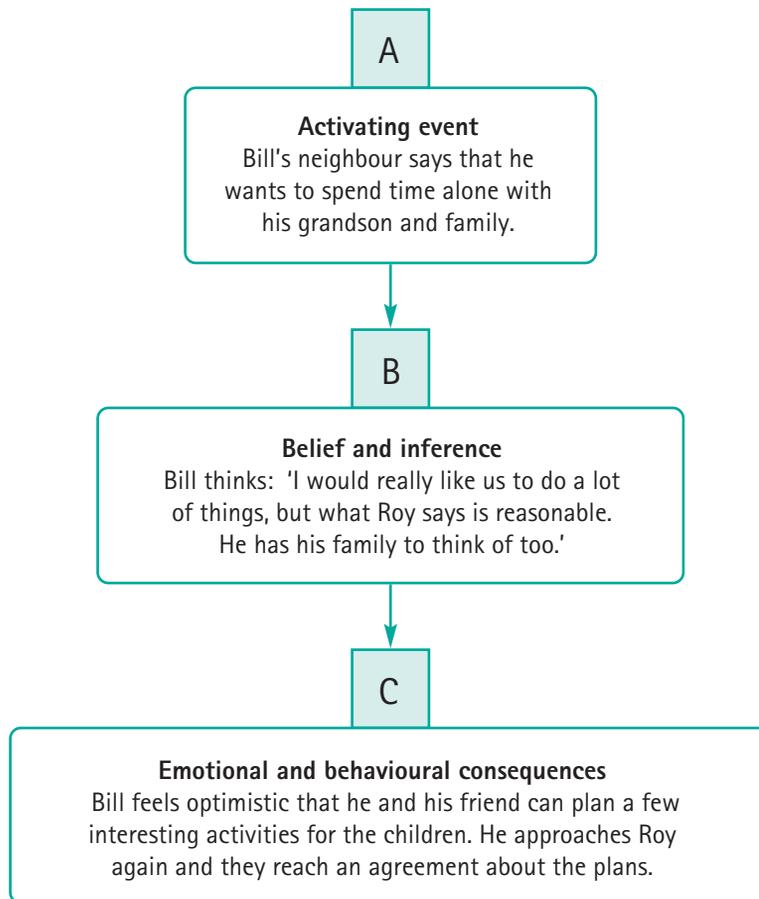


**Figure 8.3** Irrational thinking and emotional disturbance

Figure 8.4 shows how Bill might have chosen to respond to the activating event described.

## Rational and irrational thinking

Ellis (1995) took the view that people have a basic tendency to be irrational as well as rational in their thinking. Irrational thinking is seen as a fundamental cause of psychological disturbance. It is developed early in life and is due, in part, to biological tendencies, but it is also the result of social learning and the emotional investment we all have in our own particular beliefs. Rational emotive behaviour therapy aims to help clients to develop more rational, less punitive, ways of thinking, and this means encouraging them to consider



**Figure 8.4** Changing irrational beliefs

the ways in which their irrational thinking of the past has contributed to numerous problems. Clients are also encouraged to work towards long-term, rather than short-term, change so that the ordinary (and less ordinary) difficulties of life are dealt with more effectively as time goes on.

### Some irrational beliefs

According to Ellis (1991), most people subscribe to a number of irrational or illogical beliefs, which lead to many of the problems experienced by clients. These beliefs, which are seldom questioned by anyone, tend to be passed from one generation to another so that they become accepted wisdom. Ellis referred to these beliefs as 'superstitions and prejudices' (Ellis, 1991: 60) and he went on to say that, in his opinion, they can only be changed through a radical shift in individual and societal outlook. The following are some of the irrational beliefs he described:

- I should be loved and approved of by everyone.
- In order to be a worthwhile person, I need to be good at everything.
- Bad people, including myself, should be severely punished.
- If things are not the way I want them to be, it's a disaster.
- I have no real control over my problems, which are caused by external factors.
- I need to keep on reminding myself of the awful things that may happen.
- It's easier to avoid than to face problems and responsibilities.
- I always need someone stronger to take care of me.
- I can't change my behaviour because of my awful past.
- I should always become emotionally engaged in other people's problems.

(Adapted from Ellis, 1991)

## EXERCISE

### Irrational beliefs

Working with a partner, look at the above list of irrational beliefs and say how many of them you subscribe to, or may have subscribed to at certain times of your life. Discuss these with your partner, paying special attention to any beliefs you have in common. Consider the origins of such beliefs and say how you think you may have acquired your own.

## Shoulds and musts

Throughout his writing on the subject of rational emotive behaviour therapy, Ellis often referred to the shoulds and musts that are frequently used by clients who seek to impose demands on themselves and others. People, for example, express the view that they must be good at certain things or that other people must always be nice to them. If these 'musts' are not realised, life is seen as intolerable, awful or not worth living. These misleading and disturbance-producing shoulds and musts are irrational according to Ellis (1995); and in rational emotive behaviour therapy, they are regarded as primary causes of emotional problems. Ellis also used the terms 'catastrophise' or 'awfulise' to describe those forms of irrational thinking which tend to cause disturbed or neurotic behaviour (Ellis, 1991: 60–88). Ellis believed that once people accept their own or other people's irrational beliefs, they are likely to produce additional anxieties or disturbances. Thus people become very anxious about their anxiety, depressed about their depression, or self-loathing about their anger towards others.

## Helping clients to change

In rational emotive behaviour therapy clients are taught the ABC model at an early stage. Clients are also encouraged to look at the 'activating event' and the 'emotional disturbance' they have experienced. Afterwards, attention is directed to the 'beliefs' and inferences that have created such a powerful

influence in the production of emotional disturbance. It is possible to teach this model effectively and quickly and most clients, apart from those who are seriously ill or confused, are able to grasp it. Clients are also encouraged to identify and dispute their ‘musts’ and any other irrational beliefs they entertain.

This is a highly active and direct approach, which incorporates elements of teaching, persuasion, debate and even humour within its repertoire. Ellis was, in fact, notable among psychotherapists and counsellors for his support of humour as a therapeutic tool. It is not something we tend to associate with therapists who, as a group, have tended to avoid it. There are various reasons for this reluctance to engage in humour, and it has to be said that humour is, indeed, often inappropriate in the therapeutic context. However, as Streat (1995) indicates, Freud admired humour and freely appreciated it in his friends and in his patients. Ellis, too, appreciated it, and he recommended the use of humour as a way of helping clients to diffuse their own seriousness and to separate themselves from stuffy outmoded beliefs (Ellis, 1995). It goes without saying that humour should never be used against clients in therapy. It also needs to be sensitively timed and appropriate to the situation. The following is an example of the way humour was used with one client who had a compulsion to check, at very frequent intervals, all the cups in the kitchen cupboard.

**CLIENT:** What we talked about last time did work quite well. Instead of checking the cups when I got home from shopping, I went out into the garden instead and did some work there. I felt a lot better about doing that. I think it’s getting better, but I still feel like counting something.

**COUNSELLOR:** The saucepans and cutlery maybe?

**CLIENT:** Oh, God, no [laughs]. Well, I am beginning to look more closely at the way I think about this checking, and I can see how I have actually been thinking the worst . . . that if I don’t count the cups, everything will go wrong and I’ll be out of control. I actually can laugh at myself now and I think that’s real progress.

## Homework and other tasks

Clients may be given homework tasks to do, and they are frequently asked to read self-help books on the subject of rational emotive behaviour therapy. Homework may include self-monitoring and recording of negative thoughts and self-sabotaging beliefs, as well as exercises in critical thinking and questioning. Written work is sometimes included in homework exercises, and this might take the form of writing down and disputing personal beliefs that may have caused problems in the past. Imagery is another technique used in this approach, and clients are sometimes asked to ‘imagine’ themselves

responding in positive ways to situations that have been problematic for them in the past.

Role play, which is used extensively in assertiveness training and behaviour therapy, is incorporated into the Ellis model. A client could, for example, role play some feared or threatening future event such as public speaking, a job interview, or an appointment to ask for a change of conditions at work. 'Modelling' is also used, but in this approach its application is not restricted to counselling sessions. It may be extended to models of positive behaviour which clients may have observed in others. Many clients are familiar with favourite characters in literature who display the kinds of personal qualities they would like to develop.

Ellis believed that distraction was a way of helping clients to deal with anxiety and depression. In simple terms, this means encouraging them to learn relaxation procedures, yoga or meditation, but it also means teaching them how to dispute the irrational beliefs that cause problems for them. Semantic correction is another interesting rational emotive behaviour technique, which is used with clients who over-generalise, or make sweeping statements (Ellis, 1995). The following is an example:

- CLIENT:** People always let me down, always. Then I get depressed and fed up.
- COUNSELLOR:** Absolutely always let you down?
- CLIENT:** Well no, but quite often.
- COUNSELLOR:** Try changing what you first said around a bit.
- CLIENT:** In what way?
- COUNSELLOR:** Instead of the statement you made, change it to this: I allow myself to become depressed and fed up when other people let me down.
- CLIENT:** Like the ABC we discussed? Yes, but it takes time to change things around like that.
- COUNSELLOR:** That's why all the practice is important.

## Dealing with shame

In Ellis' view feelings of shame, guilt or inadequacy are responsible for many of the problems that prompt people to seek help in therapy (Ellis, 1991). In order to help clients deal with these feelings, he devised 'shame-attacking' exercises. People who are fearful of exposing personal weakness, or those who are inhibited about expressing themselves, are encouraged to take risks and engage in some form of activity that will prove to them their fears are exaggerated. A client might, for example, be asked to become more gregarious socially, in dress, behaviour or manner. The purpose behind this approach is to show clients that they need not feel ashamed, nor will anything awful happen to them if they take more risks.

## Contracts and commitment

Rational emotive behaviour therapy can be used as a brief therapy, but it is also suited to longer-term counselling when necessary. A primary focus of the model is to help clients understand the connection between thinking and emotional disturbance, which means they also need to understand the purpose of the exercises they are asked to do. Commitment to completion of assignments is important too, and any tasks clients do should be discussed in later counselling sessions. The behavioural focus in rational emotive behaviour therapy requires that clients receive ‘positive reinforcement’ for any progress they make. A working contract is always established at the beginning of therapy, the terms of which are detailed and specific.

## The therapeutic relationship

We have seen that rational emotive behaviour therapy is an active, directive and teaching approach to counselling. These characteristics set it apart from many of the other models discussed in this book. However, the actual relationship between counsellor and client is just as important in this approach, as it is in any other. Dryden (1999) suggests that flexibility is an essential attitude on the counsellor’s part. What works with one client may not necessarily work for another, so counsellors need to be open to the needs of individual clients. The counselling relationship is an egalitarian one, although equality may not be obvious at the beginning of therapy, when clients are disadvantaged because of the problems which preoccupy them. Once therapy is established however, counsellors are frequently willing to disclose information that is seen as helpful or encouraging for clients. This might include details of problems similar to those experienced by the client.

The Rogerian concept of empathy is problematic in rational emotive behaviour therapy, where attitudes of detachment and understanding are valued highly. Counsellors need to be separate from the irrational views clients express, and this means refusing to collude with, or support, these views when they are articulated. The concept of ‘transference’ is also viewed differently in this approach. Indeed, the idea that the counsellor should encourage a client’s irrational dependence is anathema, and contrary to all the basic principles of rational emotive behaviour therapy. ‘Debate’ has a central place in the model and is meant to encourage openness and honesty between client and counsellor. In a document published on the internet, Ellis (2005) highlighted the point that REBT therapists give all clients unconditional positive regard, no matter what these clients have done or what mistakes they have made. He added that therapists also teach their clients to accept themselves totally, in spite of the shame and guilt that they may experience because of their failings. Unconditional positive regard is, as shown in Unit 5, a Rogerian concept, but it is one that Ellis was concerned to emphasise in his own approach to clients.

We have seen that humour is frequently used, and this goes along with an atmosphere of informality meant to encourage creative and less rigid attitudes in clients generally. On the other hand, there are clients who prefer a more formal approach and those wishes are centrally accommodated in the model. ‘Logic’ and ‘persuasion’ are valuable skills, which are also used extensively in rational emotive behaviour therapy.

## Group work

Rational emotive behaviour therapy is often conducted in a group setting. Although resistant to the idea of group therapy initially, Ellis later came to regard it as an ‘excellent medium’ for helping clients (Ellis, 1991: 113). All the advantages of groupwork apply to rational emotive behaviour therapy, but there is an added bonus in the sense that more people are available to dispute their own and other people’s irrational beliefs and statements. Therapy can take place in small groups or large groups, although Ellis himself favoured the large group setting, which he saw as more lively with more interesting material available for discussion (Ellis, 1991).

Another significant aspect of rational emotive behaviour therapy group work is that all the members are taught the principles of the approach. This means that individual participants can (with the guidance of the group leader) take turns in the role of facilitator or therapist, an experience that is empowering for them. Some members of the group may also attend individual therapy sessions; when this is the case, the group can supply the extra support often needed to consolidate the progress made in the individual setting.

## Clients who benefit from this approach

Clients who lack assertiveness, or those who experience problems in relation to negative thinking and depression, are likely to benefit from a rational emotive behaviour approach in either an individual therapy, or a group work setting. Those who need specific interventions, such as family or marital therapy, may also be helped by therapists who are trained to use the model. Rational emotive behaviour therapy is accessible and fairly easy to understand, which means that the majority of clients (or at least those with the types of problems already mentioned) can benefit from it. The principles of the approach can be applied to education and child therapy as well, and this flexibility of application is one of its main assets.

Corey (2007) makes the point that the focus on learning and teaching, which is central to rational emotive behaviour therapy, ensures that many clients regard it in a positive light and untainted with associations of mental illness. In addition, there are many clients who welcome the stress on action

under the direction of the therapist. Tasks like homework and role play may motivate those clients who would normally find it difficult to move into action without some support, initially at least. Putting ideas into action can inspire a real sense of achievement, though clients need to be committed and reinforced for all the gains they make. Rational emotive behaviour therapy can also be viewed as a self-help approach, since it advocates reading, listening to tapes, attendance at lectures and workshops, and generally becoming independent in the search for improvement and change. This aspect of the model helps to give confidence to those clients who use it. Clients are further encouraged to view themselves as capable of making change, regardless of any past traumas they may have suffered.

### Some limitations

Clients who wish to conduct an in-depth study of childhood events and attendant traumas are unlikely to seek rational emotive behaviour therapy in order to do so. This is because the approach tends to minimise the past, although this does not imply that Ellis regarded the past as irrelevant in any way. On the contrary Ellis, who trained in Freudian psychoanalysis, was aware of the influence of past events, but he came to believe that little progress could be made through dwelling on them (Ellis, 1991).

To Ellis' own surprise, the REBT methods he devised produced quicker and more lasting results than those gained through deep analysis. However, critics of rational emotive behaviour therapy stress the point that fast methods can produce fast results, which may, in the end, be fairly transitory. The active, directive and action-based nature of the approach may not appeal to some clients and, indeed, there are probably a few who could feel quite threatened by it. If certain irrational beliefs are too vigorously disputed early in therapy, clients may vote with their feet and leave. On the other hand, as Weinrach (1995) has suggested, this type of situation can be avoided by the therapist's attention to the client's subjective experience of the problem. This requires empathy on the part of the therapist or counsellor and an attitude of respect for the client, whose difficulties feel unique to him or her.

## Aaron T. Beck (1921–)

Like Ellis, Aaron Beck started his professional career as a psychoanalyst. Like Ellis, too, Beck experienced doubts about the effectiveness of psychoanalysis in dealing with psychological problems. In particular, he was sceptical about the usefulness of the classical model in dealing with forms of mental illness,

including depression (Beck, A., 1977). Both Beck and Ellis developed their respective theories almost simultaneously, but there are some differences of stress and focus in their individual approaches. However, there are many similarities, too, since both are primarily concerned with cognition and with clients' maladaptive thought processes, as well as the situations and contexts that prompt these. In addition, both Ellis and Beck developed models of therapy that are practical and directive with an emphasis on working closely with clients to identify faulty thinking and to change it. Both also included the practice of behavioural exercises to empower clients and to facilitate progress in therapy.

## Beck's cognitive therapy

Much of Beck's seminal work was carried out during the 1960s, when his research and clinical work led to the development of cognitive therapy as a treatment for depression. In fact, Beck's cognitive therapy evolved mainly from a detailed and systematic investigation of the thoughts and beliefs (cognitions) of his anxious and depressed patients. His research showed him that depressed and anxious people are preoccupied with thoughts that exacerbate or heighten their negative mood (Beck, A., 1977). These persistent and preoccupying thoughts are often so automatic that people are unaware of their insidious influence. A depressed person might, for example, respond to a perceived slight by instantly thinking: 'She doesn't like me, so I'm not worth much'. A central focus of cognitive therapy is to help clients identify the automatic thoughts that tend to emerge, especially when they are anxious or under stress.

In her book, *Cognitive Behaviour Therapy: Basics and Beyond*, Beck's daughter, Judith, offers a succinct definition of cognitive therapy and the theory underpinning it. She proposes that 'dysfunctional thinking is common to all psychological disturbance' and suggests that when clients in therapy are taught to change their dysfunctional thinking to more realistic and adaptive assessments, they will improve emotionally and behaviourally as a result (Beck, J. S., 2011: 3).

It follows from this definition and records of the early work carried out by Aaron Beck (1977) that a central principle of his cognitive therapy is, indeed, the idea that faulty thinking is the root of many psychological problems. Beck's educational model of therapy aims to effect lasting change in the way clients think about themselves and other people. Through modification of negative beliefs, clients are empowered to see themselves and others more realistically and with fewer negative connotations. The following case study is an example.

## CASE STUDY

### Automatic thoughts

Vicky wanted to learn to drive for her work, but was convinced she wouldn't be able to because she suffered from nerves. Vicky confided in her counsellor, adding that each time she imagined herself driving she was overwhelmed by negative thoughts. The counsellor asked her to describe this experience.

**COUNSELLOR:** Tell me what you're thinking when you have that experience.

**VICKY:** I immediately think I can't do it ... I haven't got the nerve.

**COUNSELLOR:** And then what happens?

**VICKY:** I feel really down. I physically slump.

**COUNSELLOR:** So your thoughts about not being able to do it lead to you feeling emotionally and physically drained.

**VICKY:** Yes, every time.

**COUNSELLOR:** Let's look at the way you think about driving. Is there any evidence that you couldn't learn to drive?

**VICKY:** Well I'm no good with mechanical things.

**COUNSELLOR:** You can't do anything that involves mechanical skill.

**VICKY:** I can use a computer, the usual things, the lawn mower and I can even do a flat pack (laughs).

**COUNSELLOR:** What was the hardest thing about learning to assemble a flat pack?

**VICKY:** Time and patience.

**COUNSELLOR:** But you did it. What is the evidence that you can't harness those qualities again to learn to drive?

**VICKY:** It's just hard to get rid of thoughts that I can't do it.

**COUNSELLOR:** What if you work on changing those thoughts that sabotage you when you contemplate learning to drive?

**VICKY:** If I could change the thoughts, I know I would feel better. I would like to work on that.

**Comment:** This is a short example of an exchange between a cognitive counsellor and a client. The counsellor in this case worked with Vicky and encouraged her to identify and record the type of automatic thoughts that intruded when she considered learning to drive. The counsellor also continued to emphasise Vicky's positive experiences (the things she had actually learned to do), in order to counter her tendency to distorted and negative thinking. She was also taught to remind herself that when she experiences automatic negative thoughts, it didn't mean they were true. In addition, Vicky was given homework and reading assignments to help her to focus on her goals.

## Anxiety-inducing thoughts

Anxiety-inducing thoughts are so automatic and subtle that clients are (initially at least) unaware of their negative and damaging effects on mood and feelings. According to Bourne (1995), automatic thoughts often appear in ‘telegraphic form’ so that an image, or one short word, often triggers other associations, memories or thoughts (Bourne, 1995: 174). An example of this is the way Vicky tells herself she ‘can’t do it’, the repetition of which is likely to evoke other negative associations stretching back to childhood. Later on in counselling, Vicky was able to identify some of the associations that were evoked by the words. These negative childhood associations included being repeatedly told by over-anxious parents that she couldn’t do certain things, because they were too difficult for her.

It is precisely because automatic thoughts, along with their associations, occur so rapidly that they tend to go unchallenged or unquestioned. Automatic thoughts can also generate panic so that certain physiological symptoms arise to compound the original problem. These physical symptoms including shallow breathing, increased heart rate, tightness in the chest and sweating are incompatible with clear and reasoned thinking. A basic tenet of cognitive therapy is that automatic thoughts are learned bad habits that can be changed. We know that it is possible for people to change other unhealthy habits of behaviour, including smoking, for example. Changing unhealthy thinking habits is also possible, though it’s not always easy, but clients can be helped to achieve this through practice and with help from cognitive therapy.

## Core beliefs or schema

The two terms ‘core beliefs’ and ‘schema’ are often used interchangeably in cognitive therapy, but there are differences. Core beliefs are beliefs about the self, which stem from early childhood, whereas the word ‘schema’ refers more specifically to ‘cognitive structures’, which contain the core beliefs (Beck, J. S., 2011: 228). Core beliefs can be positive or negative; while most people have sufficient positive core beliefs to maintain personal equilibrium, negative beliefs can emerge during periods of anxiety or stress. These core beliefs, which are deeply embedded, are so fundamental and unchallenged that they are regarded as true, even when the evidence points otherwise. They tend to be concerned with the world and familial attitudes to it and are carried forward from one generation to another. In common with many other approaches – including the psychodynamic, transactional analysis and behaviourism – cognitive therapy stresses the importance of early childhood experience and recognises that many later problems are due to childhood difficulties. Many of these early experiences give rise to distorted or erroneous thinking. In addition, these negative experiences, combined with emotional attitudes transmitted by parents, predispose many people to emotional problems, including depression. Some examples of core beliefs include:

- I'm a failure if I don't have a partner.
- I'm no good at practical tasks.
- Things never turn out right for me.

We can see at once that these examples of negative core beliefs have much in common with the irrational beliefs described by Albert Ellis in rational emotive behaviour therapy.

Judith Beck (2011) points out that in addition to the core beliefs held, people also tend to discount any information to the contrary and, instead, 'focus selectively' on information that confirms them (Beck, J. S., 2011: 32). A central focus of cognitive therapy is to encourage clients to consider how they have acquired their deeply held beliefs and then to show them how these can be changed. The counsellor's intervention in the case study outlined above was to show the client (Vicky) that she had accomplished practical tasks before; therefore, her belief that she was incapable of learning new skills was erroneous. People often start from a position of negative beliefs about their own level of competence, and they are often surprised when core beliefs are challenged, or strengthened, by contradictory evidence. Free (1999) makes the point that many beliefs (collective and individual) have changed throughout history: it is perfectly possible, therefore, for clients to modify long-held personal beliefs that hinder them in the present. A distinction between core beliefs and automatic thoughts should be made here, since automatic thoughts are the images or words that accompany core beliefs, and are specific to any given situation (Beck, J. S., 2011). A person may, for example, have the negative core belief 'I'm no good', which is then followed (after some minor mistake or failure) by the automatic thought 'stupid' or 'incompetent'. An immediate reaction to this process is emotional, behavioural and physiological, as we saw in the case study example of Vicky.

## EXERCISE

### Core beliefs

In this exercise you are asked to identify any core beliefs that stem from your childhood. Did you believe these to be absolutely true as a child and, if so, do you still believe them to be true? Work with a partner and discuss the most common childhood beliefs and how you were both personally affected by them. Discuss how individual and collective beliefs change over time.

## Logical errors

'Logical errors' is a term that describes a tendency, often seen in depressed people, to think in a distorted or erroneous way (Beck, A. 1977). This mode of cognition can also be described as forms of extreme or arbitrary thinking that usually involve exaggeration. Logical errors also tend to

disregard reality. A depressed person may, for example, draw a conclusion that has no real bearing on the situation. For example, 'I just know I won't do well in the exam because I failed that subject at school', exemplifies this form of distorted thinking. Selective abstraction is yet another aspect of illogical thinking, and involves emphasising a single element of the environment, while ignoring everything else; for example, 'I missed the bus this morning, so nothing will go right.' Overgeneralisation is another form of primitive thinking, which Judith Beck describes as a tendency to 'make a sweeping negative conclusion', which is then applied to every situation (Beck, J.S., 2011: 182). This general rule is usually derived from one isolated incident, such as, for example, 'I can't do anything right'. Sometimes events are magnified, thereby getting the general scale of things out of proportion. The statement 'If I fail my driving test this time, I'm hopeless' is an example of magnification of the actual situation. By the same token a situation may be minimised, also distorting reality; for example, 'I don't care about exams anyway, they don't mean much.' 'Personalisation' is another trait highlighted by Judith Beck, and describes a tendency (often seen in depressed people) to take everything personally, even though there is no real reason to make this kind of connection (Beck, J. S., 2011:182).

## The therapeutic relationship

Judith Beck highlights the importance of establishing a good relationship from the outset with clients. This she sees as a prerequisite for a 'positive alliance' and can be accomplished through the use of good counselling skills, a variety of styles, joint decision-making, especially in regard to treatment plans, feedback, and open communication. This approach is designed with a view to helping clients solve their difficulties and overcome their problems (Beck, J. S., 2011: 18).

Throughout counselling sessions it is essential to check with clients that they understand the process taking place, they agree with it, and they are given the opportunity to correct any inaccuracies or misunderstandings that may emerge. Cognitive behaviour therapy is a highly structured approach, which also incorporates a teaching and educational dimension. In addition, it is directive with an emphasis on activity as an aid to client empowerment. Activities include homework and other assignments, role play, rehearsal, social skills and assertiveness training, and challenging negative self-statements. Techniques derived from behaviourism are used in cognitive therapy, too, including positive reinforcement and systematic desensitisation, described earlier in this unit. Clients' full participation is essential; this includes asking them to state which problems they wish to address during individual sessions. Clients need to know what to expect during therapy, and this understanding can be achieved through clear communication and feedback.

## Brief cognitive therapy

One of the advantages of cognitive behaviour therapy is that it is adaptable enough to meet the needs of individual clients. Both REBT and Beck's cognitive therapy are often used as time-limited or short-term approaches, encompassing a specific number of sessions. This number can vary, but is usually six to ten weeks in duration. Curwen et al. define brief therapy as an approach in which 'maximum benefits' can be achieved, with the advantage of low cost to clients. They also make the point that 'purchasers' of psychotherapy, whether individual clients or organisations like the NHS, expect value for money (Curwen et al., 2000: 2). In addition to being less expensive, brief therapy has other advantages for clients, especially those who cannot afford the investment and time needed for more extended therapy. When people encounter difficulties, especially emotional or psychological difficulties, they tend to want fairly quick results. In fact, cognitive therapy has always tended to be brief and this is something that Ellis (1995) highlights. Beck, too, suggests that practitioners of cognitive therapy can use techniques in a medical or similar setting 'without conducting a full therapy session' (Beck, J. S., 2011: 3). This highlights the adaptability and versatility of cognitive therapy, and confirms that cognitive therapists place client needs at the forefront of their philosophy.

In recent times the demand for time-limited helping approaches has increased. This increase is not just the result of financial constraints, but is also linked to greater uptake of therapy and the need for quick (and verifiable) results.

### KEY TERM

**Brief therapy:** Counselling which often takes place over six to eight weeks, or it may even be less. Brief therapy is characterised by clarity of focus and by the client's motivation in achieving results in the time allocated.

## George Kelly (1905–1966)

George Kelly, who unlike Ellis and Beck, did not have a background in psychoanalysis, contributed in his own very individual way to the field of cognitive therapy. Kelly, who was born in Kansas, studied psychology and spent many years engaged in clinical work, then later became Professor of Psychology at the University of Maryland where he continued for 20 years. In 1955 he wrote and published his major work in two volumes, entitled *The Psychology of Personal Constructs*.

Kelly was not limited to one discipline but was qualified in a diverse range of subjects, including maths, education and physics. In the development

of his theory of personal constructs, Kelly abandoned all other former theories of personality, including those intrinsic to both the Freudian and behavioural approaches. According to Ewen (1993), Kelly preferred to 'leave all familiar landmarks behind' including the concepts of ego, motivation, drives, reinforcement and even the unconscious (Ewen, 1993: 344).

It is clear, therefore, that in formulating his psychology of personal constructs Kelly wanted to start with a blank sheet, with the clear and specific aim of helping people to overcome interpersonal problems (Kelly, 1955).

## Personal constructs

According to Kelly's theory of personal constructs, we all build mental theories about the environment in which we live, constantly testing these hypotheses against reality as we go along, and modifying them depending on how accurate they turn out to be. We do this in order to make sense of the world, to exercise some control over our environment and to make it more predictable. Although we may not always be accurate in the way we construe reality, it is, nevertheless, our own individual and creative interpretation which, as Ewen (1993) points out, 'gives events their meaning and determines our subsequent behaviour' (Ewen, 1993: 345).

There are some similarities between Kelly's theory of personal constructs and Beck's theory of schema or core beliefs, since both represent very personal attitudes that are firmly held and can be either positive or negative. A person's core beliefs or constructs cannot be accurately judged by other people to be positive or negative, however, since each person's experience is entirely unique and experiential. In counselling, therefore, the therapist's task is to understand the client's individual experience (which requires empathetic listening) and the ways in which these experiences have been formed. From Kelly's perspective, it is pointless to impose our own constructs on other people, though the goal of therapy is to help clients experiment with new core constructs, in order to detach from old and dysfunctional ones (Kelly, 1963).

Although much of Kelly's scientific theory and the terminology he uses is complex, the strength of his contribution lies in his emphasis on the importance of subjective cognition and the central role of empathy in understanding other people's experiences. In addition, his theory upholds the idea of personal uniqueness, along with the concomitant need to respect this. Criticisms have been levelled against Kelly's approach, including the view that he neglects attention to other human characteristics such as love and hate, sexuality, aggression, hope and despair. In addition, Ewen (1993) points out that Kelly paid no attention to experiences of infancy and childhood, thereby leaving himself open to charges of oversimplification by members of the psychoanalytic and behavioural communities. In response to these perceived deficits, some researchers, including Bannister (1985), have sought to redress the balance by directing attention to human emotions and theories of personality and away from purely isolated cognitive issues.

**EXERCISE****Interpreting events**

Working in pairs, discuss the ways in which groups of people often give different accounts of the same event. What are the factors that predispose people to interpret things so differently? Can you relate your discussion to Kelly's theory of personal constructs?

## Mindfulness-based cognitive therapy (MBCT)

Within the past decade, the practice of mindfulness as an aid to mental health has become increasingly popular. Mindfulness, however, has a long and impressive lineage stemming from Eastern medicine, stretching back into antiquity. Within recent times, Western psychological medicine has begun to recognise its importance and has incorporated its concepts into the cognitive behavioural model of therapy. The development of mindfulness-based cognitive therapy has been applied to the treatment of depression, in particular, but its scope is gradually extending to encompass all aspects of psychological and emotional difficulties.

Professor Mark Williams of Oxford University is a researcher and pioneer in the field of mindfulness and is co-founder, along with colleagues, of mindfulness-based cognitive therapy, or MBCT. Williams and his colleagues have studied depression, anxiety and stress over a period of 30 years and have established that it is possible to tackle these problems through the practice of mindfulness as part of daily life. Moreover, they have designed a series of practices, which can be used by anyone, and they stress the effectiveness of these (as shown in clinical trials), particularly in alleviating depression (Williams and Penman, 2011).

Mindfulness practice is relatively simple, and can be used to prevent everyday feelings of stress and anxiety escalating out of control. It is based on self-observation, carried out without judgment or censure. There is an emphasis on compassion for self, especially when depression or anxieties strike. At its simplest level it means focusing attention on breathing, so that all negative self-talk recedes into the background. We are aware, initially, of the negative monologue inside our heads, but mindfulness teaches that we can stand back from it and listen without criticism. In some respects, the deep breathing exercise described here is reminiscent of the exercise described earlier in this unit, but it also goes beyond this. Williams and Penman (2011: 6) describe it as a 'method of mental training', the practice of which does not take a long time and can be achieved by anyone.

One way of defining mindfulness is to say that it is the very opposite of mindlessness. When we do something in a mindless way we sleep-walk through the process, whereas doing it mindfully implies a conscious awareness of every step and paying attention in the present. We can fulfil everyday tasks in this way; for example, brushing our teeth or getting dressed. This type of practice anchors us to the present (the here and now) so that thoughts of the past and the future do not intrude. Paying attention to the present enables clients to deal with anxieties and emotions, which ordinarily might overwhelm them. They can be taught that instead of trying to decipher the meaning of stressful or anxious thoughts, they should simply observe them without criticism or comment. In this way, clients can learn that thoughts do not define us, but are constantly changing. This is where attention to breathing is important, because it draws attention back to the present and away from the past, which no longer exists, and the future, which has not yet arrived. Deep breathing is not the only method of drawing attention back to the present, however. Attention to any of the senses will act in a similar way. One client described her experience in the following way:

## CASE STUDY

### CLIENT

I was anxious and worried about getting the results of my scan. Just before I left for the hospital, I went out to the back garden to take clothes off the line. The scent of the rose bushes suddenly stopped me in my tracks. The perfume was all around me. I stood still, taking in the aroma and feeling my feet planted solidly on the ground. The experience simply took me over so that I felt rooted (like the roses bushes) in the ground. Anxieties about the scan results receded. I didn't have to think about it now while I stood there in the garden.

Comment: In this example, the client's sense of smell and her attention to her own feet planted firmly on the ground served as anchors and calmed her down.

Williams and Penman make a distinction between what they refer to as 'Doing mode' and 'Being mode'. When in Doing mode we tend to be on 'autopilot', where we end up performing tasks without clear awareness of what we are doing. Being mode, on the other hand, implies full consciousness of what we are doing (Williams and Penman, 2011: 34). A central aim of mindfulness therapy is to encourage clients to avoid being sidetracked by autopilot so that they become more fully alive and aware in the present. This does not mean telling them to avoid difficulties, especially difficult feelings. On the contrary, it means encouraging clients to allow these feelings to

emerge and to acknowledge them, but with compassion and interest. This more compassionate and non-judgmental approach gradually diminishes the power of such feelings to overwhelm clients.

In order to help clients through MBCT, it is important to teach them its concepts and to emphasise the research that underpins its effectiveness. When clients understand that it is possible, through neuroscience and brain imaging, to see positive changes in the human brain brought about by the practice of mindfulness, they are usually impressed. Practice is an important element of the approach, and a series of daily exercises is usually recommended over a period of eight weeks. In the UK the National Institute for Health and Clinical Excellence (NICE, 2008) has (in its guidelines for depression) recommended MBCT for people with a history of three or more episodes of depression (Williams and Penman, 2011).

## Solution-focused brief therapy

We have seen that Ellis' REBT and Beck's cognitive therapy are approaches that highlight the place of cognition in the development and continuation of personal problems. Another more recent development, called solution-focused brief therapy (SFBT), picks up the theme of cognition, or thinking in the context of psychotherapy. However, the difference here is that SFBT also encourages clients to think in terms of mental wellbeing, and finding solutions to the difficulties they experience. It is true, of course, that all forms of therapy are meant to empower clients in this way, but a key element of SFBT is that it emphasises health, rather than psychopathology, and encourages a focus on encouraging this more positive goal.

SFBT was developed and pioneered by Steve de Shazer (1998) and his colleagues who worked at the Brief Family Centre in Milwaukee, USA from the mid-1980s. Another important seminal figure in the approach was an American psychiatrist called Milton H. Erickson, who died in 1980. O'Hanlon and Weiner-Davis (2003) describe Erickson's unique and often creative approach to helping clients to find solutions to their problems. These methods were ostensibly eccentric, but seemed to work well, not least because they focused on clients' competence and individual strengths.

Though SFBT continues to grow and evolve, its underlying assumptions remain constant. O'Hanlon and Weiner-Davis identify a number of these assumptions, including the following:

- 1 'Change is constant'. Since the whole universe is in the process of ongoing change it is fair to say that clients' problems are not static, but are changing too (O'Hanlon & Weiner-Davis, 2003: 35). In SFBT, therefore, the counsellor steers the focus away from how the client's problems have been

or are, and towards the way in which they are changing. Often clients don't see the change until they are invited to consider it.

- 2 It is not necessary to gather extensive information about a problem in order to resolve it. Practitioners of SFBT believe that counsellors can spend too much time seeking information about problems, when they should be spending time on solutions.
- 3 It is not necessary to know what caused a problem in order to resolve it. Even if a client 'knows' why she drinks too much, for example, it won't automatically alleviate the problem. In SFBT the central aim is to overcome the problem by looking at solutions rather than causes.
- 4 In SFBT a small initial change can be seen as a catalyst for other bigger changes. Often clients get depressed because it all seems too much. Initial changes can also be very fast. SFBT practitioners believe in the possibility of rapid change leading to solutions. In addition, practitioners believe that the counsellor's conviction will ultimately affect the client's perception of what is possible in a short space of time.
- 5 Clients are the experts, they have the resources and they define their own goals. SFBT acknowledges that all clients are unique and know their own situations better than anyone else. In SFBT, solutions should be formulated to meet these unique needs, rather than the dictates of a particular set of theories.

O'Hanlon and Weiner-Davis (2003)

### Skills used in solution-focused brief therapy

The way in which language is used by the counsellor is especially significant in SFBT. One aspect of this is the practice of matching the client's language. If, for example, a client describes an argument with a partner as a 'barney', the counsellor would use this term to mirror what has been said. To use another term would distort what has actually been said. Solution talk is always encouraged: though the client may be prompted to talk in terms of problems, the counsellor will seek to concentrate on solutions and will encourage the client to do the same. The counsellor will always ask open questions designed to encourage positive ways of considering change. The following are some examples:

- 1 What progress have you made since last time?
- 2 What are your coping strategies?
- 3 How will you know when you have reached that goal?
- 4 What positive things have been happening since?

During their first session, rapport is established between client and counsellor. After this, there is a fairly rapid focus on positive solutions and establishing goals. During subsequent sessions, positive change is assessed and the details are established. Any positive change that has taken place is acknowledged and reinforced by the counsellor's response to the client.

**EXERCISE****The miracle question**

In SFBT the focus is always on looking at the solution aspect of each client's situation. This solution principle underlies a technique called the 'miracle question', which is central to this approach. Working individually, think of a difficulty that you currently have. Then answer the following question, which is based on de Shazer's original technique (de Shazer, 1988):

Suppose that one night when you went to sleep, there was a miracle and your problem was solved. When you woke up in the morning, how would you know it was solved and what would be different?

**Comment:** The answer to this question should give you some idea of what your future would be like without the problem. In SFBT terms, this vision of a problem-free future should act as a catalyst to help you achieve it. Discuss your response to the exercise with members of your training group, saying how effective or otherwise you believe it to be.

## Cognitive behaviour therapy today

The profile of cognitive behaviour therapy (CBT) has steadily increased in the UK and, indeed, worldwide. The enhanced prominence of CBT as a therapy of choice in the UK is linked to the Improving Access to Psychological Therapies (IAPT) initiative, which was launched in 2008. According to this initiative, access to 'evidence-based psychological therapies' will be available by 2015 for at least 15 per cent of the adult population (Department of Health, 2012). The National Institute for Health and Clinical Excellence (NICE) backed this proposed programme in 2008 and suggested that CBT should be recommended for a range of psychological problems, including depression, anxiety and panic disorder.

Another reason for the expansion of CBT as a preferred approach to helping clients, with anxiety and depression in particular, is its evidence-based status within counselling and psychotherapy generally. Much research has been carried out in relation to CBT, and results indicate its effectiveness for a range of psychological problems (Cooper, 2008). In addition, the Royal College of Psychiatrists stress on its website (2013) that CBT has been shown to help with many problems, including stress, phobias, depression and anxiety. Numerous research projects are detailed on the internet which highlight the effectiveness of CBT for a wide range of psychological problems; and increasing numbers of practitioners,

including doctors, nurses and health visitors within the NHS are being trained to use it.

The research-based effectiveness of CBT (which is by no means confined to the UK) has surprised many practitioners, who have been trained in, and use, other approaches to helping clients. Some, including Yalom (2004), have expressed reservations about the effectiveness of CBT in the long term. His basic concern is that any gains that clients make in the short-term with CBT may not be maintained once they leave therapy. In Yalom's view, 'chronic distress requires far longer therapy' (Yalom, 2004: 224). He also points to the fact that clients frequently make quick gains at the start of therapy, a phenomenon that does not mean their problems are satisfactorily resolved. Another critic, psychoanalyst Darian Leader, expressed his view in the *Guardian* newspaper, describing CBT as 'a quick fix for the soul', whose aim is to get rid of symptoms (Leader, 2008:1). He contrasts this objective with other psychotherapeutic approaches that seek to understand what a client's symptoms could actually be saying.

Other writers, including Moloney and Kelly (2008), acknowledge that aspects of CBT may be helpful, but highlight environmental factors (including social and economic deprivation), which frequently contribute to psychological distress. Ignoring these factors is, in their view, one way of saying that they really don't matter. Furthermore, encouraging clients to adjust their thinking in such circumstances is misleading for clients and therapists alike. Proctor (2008) refers to the fact that CBT 'invests much authority in therapists', who are believed to know what is best for their clients, with little thought given to the dangers of such assumptions (Proctor, 2008: 253).

In relation to issues of power and control in CBT, it is worth remembering that Aaron Beck and Albert Ellis, the original pioneers of CBT, both began as psychoanalysts and later became disillusioned with psychoanalysis. Both were concerned to develop a form of therapy that was more located in clients' actual experiences, and did not require subscribing to Freudian theories about the past and its influence on the present. In addition, both Ellis and Beck wanted to develop a form of therapy that could be delivered in a shorter time span than psychoanalysis, and they envisaged CBT as a collaborative endeavour between client and therapist. To those who allege that CBT is authoritarian or controlling, Ellis pointed out that 'virtually all psychotherapies' can be described in this way (Ellis, 1991: 364). This is because all therapists, on account of their experience and training in a particular field, are, in fact, always in some kind of authority. Neither Ellis nor Beck envisaged CBT as a static theoretical approach to therapy; instead, they saw it as dynamic and evolving in a way that would meet the changing needs of clients.

Already there is evidence that CBT is changing to meet the diverse needs of clients. Many of these changes are linked to research, for as Palmer (2008) suggests, CBT is a 'pragmatic approach' that is not weighed down by dogma or rigid adherence to one particular set of skills (Palmer, 2008: 6).

These changes include incorporating aspects of other theoretical approaches to counselling within CBT, including person-centred empathy, elements of Gestalt counselling and aspects of object relations theory.

Not everyone is happy with this developing eclecticism and some, including Loewenthal and House (2008), suggest that there is the possibility of 'opportunistic exploitation' of other theoretical approaches, aspects of which are 'bolted on' to CBT (Loewenthal and House, 2008: 292). In their view, a corollary of this add-on approach is that it exposes CBT, with its strong scientific claims, to the opposite charge of being unscientific.

## CBT and the internet

One area in which CBT has superseded all psychotherapeutic approaches is its seamless transferability to the internet. Online counselling is now well established, and when we consider that people use the internet for so many other purposes today, it is easy to see how this transition has come about. CBT is delivered online in two main ways: the first mode of delivery is via self-help programmes, which guide users step by step through them. The second method is when CBT is delivered, in real time, by a therapist working online. Research carried out at Bristol University and described by Kessler (2009) in the medical journal the *Lancet* concludes that CBT is effective for depression when delivered by a therapist online in this way. The researchers infer from these results that online counselling could be used in future to broaden access to CBT generally. Increasingly, counselling support is delivered online via email or Skype, depending on the needs of clients; fees may be cheaper than conventional counselling and are usually paid by subscription.

One criticism of online counselling is the absence of a therapeutic relationship when it is delivered in this way. However, an important point to remember is that clients do, in fact, have a relationship with a counsellor when using the internet for help. It is just that the counsellor is not face to face in the same room, and therefore not as immediately present as in the traditional counselling context, but this may suit some clients, especially those who cannot access help in other ways. Additionally, there are clients who prefer the comfort and seclusion of their own homes, while others value the anonymity certain forms of online counselling provide. As well as this, online counselling is often available over large geographical areas so clients are offered a wider choice of therapists. There is flexibility, too, in terms of timing, though this aspect needs to be negotiated between therapist and client, just as it would be in conventional counselling. Clients with certain problems, disability or social phobia, for example, or those who live in isolated or remote areas, may feel more secure when receiving help online. The difficulty here is that problems of isolation and loneliness may

be compounded, if online help is used without any progression to social interaction or other forms of support.

One positive development in relation to online counselling is the provision of specialist training for counsellors already trained in traditional counselling methods. This means that the practice of online therapy has moved forward considerably, and some aspects of it that initially caused concern are now being addressed. These include ethical issues relating to the protection of client confidentiality and online identity, as well as proof of counsellor training and accreditation. There are some client issues (including suicidal feelings or violent impulses), which online counsellors consider incompatible with their particular mode of delivery. Like counsellors everywhere, online providers are obliged by law to report threats of violence to the relevant authorities. This may be easier said than done if client and counsellor are distanced geographically.

## SUMMARY

Cognitive behavioural approaches to counselling were the subject of this unit. In the first instance, the foundations of behaviourism and the experiments underpinning it were considered. The contributions of Pavlov, Watson, Thorndike, Skinner, Wolpe and Bandura were highlighted and placed in the context of therapeutic practice and their relevance to cognitive behaviour therapy.

The primary focus of this unit was, however, the work of two pioneering cognitive therapists: Albert Ellis and Aaron Beck. The development of Ellis' rational emotive behaviour therapy was described, along with the factors which influenced his work. The ABC model was outlined in some detail, in addition to the nature of the counsellor–client relationship. The theories and work of Aaron Beck were similarly described, and examples of techniques and procedures used in both rational emotive therapy and cognitive behaviour therapy were discussed.

We also considered the use of both brief cognitive behaviour therapy and solution-focused therapy. Mindfulness-based cognitive therapy was included, and a summarised overview of online counselling, along with its benefits for certain clients was discussed. Finally, in this unit we looked at some of the research findings relating to cognitive behavioural therapy, highlighting its increasing prominence as the therapy of choice in health care and other settings.

## References

- Avery, B. (1969) *Principles of Psychotherapy*. London: Thorsons Publishing Ltd.
- Bandura, A. (1977) *A Social Learning Theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bannister, D. (1985) (ed.) *Issues and Approaches in Personal Construct Theory*. Orlando, FL: Academic Press.
- Beck, A. (1977) *Cognitive Therapy of Depression*. New York: The Guilford Press.

- Beck, J. S. (2011) *Cognitive Behaviour Therapy: Basics and Beyond*. New York: The Guilford Press.
- Bourne, E.J. (1995) *The Anxiety and Phobia Workbook*. California: New Harbinger Publications Inc.
- Cooper, M. (2008) *Essential Research Findings in Counselling and Psychotherapy*. London: Sage Publications.
- Corey, G. (2007) *Theory and Practice of Counselling and Psychotherapy*. Pacific Grove, CA: Brooks/Cole.
- Curwen, B, Palmer, S. & Ruddell, P. (2000) *Brief Cognitive Behaviour Therapy*. London: Sage Publications.
- Department of Health (DH). (2012) 'Improving Access to Psychological Therapies (IAPT). (online) *No Health without Mental Health: A Government-Funded National Project to Improve Mental Health and Wellbeing*. November 2012. Available at: [www.iapt.nhs.uk/silo](http://www.iapt.nhs.uk/silo). Accessed July 2013.
- de Shazer, S. (1985) *Keys to Solutions in Brief Therapy*. New York: W. W. Norton & Co.
- Dryden, W. (1999) *Rational Emotive Behavioural Counselling in Action*. (2nd ed) London: Sage Publications.
- Ellis, A. (2005) 'The Essence of Rational Emotive Behaviour Therapy: A Comprehensive Approach to Treatment' (online). New York: The Albert Ellis Institute. Available at: <http://www.rebtdnetwork.org/library.html>. Accessed 12th July 2013.
- Ellis, A. (1995) 'Fundamentals of Rational Emotive Behaviour Therapy for the 1990s', in Dryden, W. (ed) (1995) *Rational Emotive Behaviour Therapy: A Reader*. London: Sage Publications.
- Ellis, A. (1991) *Reason and Emotion in Psychotherapy*. New York: Citadel Press.
- Ewen, R.B. (1993) *An Introduction to Theories of Personality* (4th edn). Mahwar, NJ: Lawrence Erlbaum Associates.
- Eysenck, H.J. (1960) 'The Effects of Psychotherapy', in Eysenck, H. J. (ed.) *Handbook of Abnormal Psychology*. New York: Basic Books.
- Free, M.L. (1999) *Cognitive Therapy in Groups: Guidelines and Resources for Practice*. Chichester: John Wiley & Sons Ltd.
- Kelly, G.A. (1955) *The Psychology of Personal Constructs: Vol. 1: A Theory of Personality. Vol. 2: Clinical Diagnosis and Psychotherapy*. New York: W.W. Norton.
- Kessler, D. (2009) 'Therapist-delivered Internet Psychotherapy for Depression', in *The Lancet* (online), Vol. 374, No. 9690, pp 628-634, 22 Aug. Available at: [www.thelancet.com/journals/lancet/article](http://www.thelancet.com/journals/lancet/article). Accessed 18th July 2013.
- Leader, D. (2008) 'A Quick Fix for the Soul', in the *Guardian*, G2 (online) 9th September. Available at: [www.theguardian.com/science/2008/sept09/psychology.humanbehaviour](http://www.theguardian.com/science/2008/sept09/psychology.humanbehaviour). Accessed 15th July 2013.
- Loewenthal, D. & House, R. (2008) 'Contesting Therapy Paradigms about What it means to be Human', in Loewenthal, D. & House, R. (eds.) (2008) *Against and for CBT: Towards a Constructive Dialogue*. Ross-on-Wye: PCCS Books.

- Moloney, P. & Kelly, P. (2008) 'Beck Never Lived in Birmingham', in Loewenthal, D. & House, R. (eds.) (2008) *Against and For CBT: Towards a Constructive Dialogue*. Ross-on-Wye: PCCS Books.
- O'Hanlon, B. & Weiner-Davis, M. (2003) *In Search of Solutions: A New Direction in Psychotherapy*. New York: W.W. Norton & Co.
- National Institute for Health and Clinical Excellence: Commissioning Guide—Implementing Nice Guidance (2008) (online) 'Cognitive Behavioural Therapy for the Management of Common Mental Health Problems', p.17. Available at: [www.nice.org.uk/media/878/abtcommissioningguide.pdf](http://www.nice.org.uk/media/878/abtcommissioningguide.pdf) Accessed July 2013.
- Palmer, S. (2008) 'Polemics and Cognitive Behaviour Therapy', in Loewenthal, D. & House, R. (eds.) (2008) *Against and For CBT: Towards a Constructive Dialogue*. Ross-on-Wye: PCCS Books.
- Pavlov, I. (1927) *Conditioned Reflexes: An Investigation of the Physiological Activity of the Cerebral Cortex*. G.V. Anrep (ed.) London: Oxford University Press (online). Available at: [www.psychcentral.com/classics/Pavlov/lecture12](http://www.psychcentral.com/classics/Pavlov/lecture12). Accessed July 2013.
- Proctor, G. (2008) 'CBT: The Obscuring of Power in the Name of Science' in Loewenthal, D. & House, R. (eds.) (2008) *Against and For CBT: Towards a Constructive Dialogue*. Ross-on-Wye: PCCS Books.
- Royal College of Psychiatrists (2013) 'Cognitive Behaviour Therapy' (online), in *Mental Health Website*. Available at: [www.rcpsyche.ac.uk](http://www.rcpsyche.ac.uk). Accessed July 2013.
- de Shazer, (1988) *Clues: Investigating Solutions in Brief Therapy*. New York: Norton.
- Skinner, B. F. (1988) *Beyond Freedom and Dignity*. London: Penguin Books.
- Stearn, H. (1995) *The Use of Humour in Psychotherapy*. New Jersey: Jason Aronson.
- Thorndike, E. L. (1911) *Animal Intelligence: Experimental Studies*. New York. The Macmillan Company.
- Watson, J. B. & Rayner, R. (1920) 'Conditioned Emotional Reactions'. *Journal of Experimental Psychology*, 3, 1, 1–14 (online). Available at: [www.psychclassics.yorku.ca/watson/emotion.htm](http://www.psychclassics.yorku.ca/watson/emotion.htm). Accessed July 2013.
- Williams, M. & Penman, D. (2011) *Mindfulness: A Practical Guide to Finding Peace in a Frantic World*. London: Piatkus.
- Wolpe, J. (1958) *Psychotherapy by Reciprocal Inhibition*. Stanford, CA: Stanford University Press.
- Weinrach, G. (1995) 'Rational Emotive Behaviour Therapy: A Tough-Minded Therapy for a Tender Profession', in Dryden (ed.) *Rational Emotive Behaviour Therapy: A Reader*. London: Sage Publications.
- Yalom, I.D. (2004) *The Gift of Therapy: Reflections on Being a Therapist*. London: Piatkus.

## Further reading

- Beck, J.S. (2011) *Cognitive Behaviour Therapy: Basics and Beyond* (2nd edn). New York: The Guilford Press.

- Bohlmeijer, E. & Hulsbergen, M. (2013) *Live A Beginner's Guide to Mindfulness: in the Moment*. Maiden head: Open University Press.
- Dryden, W. & Neenan, M. (2004) *Rational Emotive Behavioural Counselling in Action* (3rd edn). London: Sage Publications.
- Garrett, V. (2010) *Effective Short-Term Counselling within the Primary Care Setting: Psychodynamic and Cognitive-Behavioural Approaches*. London: Karnac Books.
- Neenan, M. & Dryden, W. (2006) *Cognitive Therapy in a Nutshell*. London: Sage Publications.
- Sheldon, B. (2011) *Cognitive Behaviour Therapy: Research and Practice in Health and Social Care* (2nd edn). London: Routledge.
- Thomas, M. & Drake, M. (2012) *Cognitive Behaviour Therapy Case Studies*. London: Sage Publications.
- Van Bilsen, H. *Cognitive Behaviour Therapy in the Real World: Back to Basics*. London: Karnac Books.
- Wills, F. & Sanders, D. (2013) *Cognitive Behaviour Therapy: Foundations for Practice* (3rd edn). London: Sage Publications.

## Resources

### Websites

[www.beckinstitute.org](http://www.beckinstitute.org)

Information about Aaron Beck and the work of the Beck Institute.

[www.babcp.com](http://www.babcp.com)

The British Association for Behavioural and Cognitive Psychotherapies (BABCP).

[www.rebtnetwork.org](http://www.rebtnetwork.org)

Describes the work of Albert Ellis as well as the theory and practice of Rational Emotive Behaviour Therapy (REBT).

[www.solutionfocused.org.uk](http://www.solutionfocused.org.uk)

Information about Solution-Focused Therapy.

[www.iapt.nhs.uk](http://www.iapt.nhs.uk)

Information about the Improving Access to Psychological Therapies (IAPS) programme.

[www.moodgym.anu.edu.au](http://www.moodgym.anu.edu.au)

This is a self-help programme which teaches CBT skills to people with anxiety or depression.

### Journals

*Behavioural and Cognitive Psychotherapy*

This is the journal of the British Association for Behavioural and Cognitive Psychotherapies.

*The Cognitive Behaviour Therapist*

This is the online journal for cognitive behaviour therapists.