

ONE

Understanding Cognitive Behaviour Therapy

Chapter objectives

By reading this chapter you will be able to:

- Place CBT in an historical context and understand that it is now a broad-based family of therapies
- Describe the fundamental assumptions that underpin CBT
- Identify common myths and misconceptions about CBT

Introduction

The cognitive behaviour therapies are concerned with exploring the personal meanings, emotions and behaviours that generate or are otherwise implicated in human difficulties. They are concerned with how a person acts (their behaviour), their thoughts, images and the way they process information (cognition), how they feel (emotion) and their physical reactions (physiology). They also take into account a person's history, biological and genetic factors and their current environment.

CBT is a broad discipline, and although united by a common set of foundational assumptions, there are a number of therapies which claim to be cognitive behavioural in focus. This chapter introduces some of these therapies and the foundational assumptions that inform them. It highlights the commitment of CBT to evidence-based practice and challenges some of the common myths that you will encounter when reading critiques of the approach. The overview provided here sets the scene for subsequent chapters which look in depth at some of the specific techniques that arise from these foundational assumptions.

Towards an understanding of CBT

CBT is a family of therapies concerned with helping people change the way they think, feel and act. It has a very wide range of application and can be used to address distressing thoughts and feelings, build new skills to tackle problems, promote well-being and help teams enhance their performance in an organisation – to mention just a few. As is the case with all approaches, CBT does not work for everyone or for all of life's concerns but, when chosen carefully, it is a powerful form of intervention that can increase a person's capacity to survive or even thrive under conditions of adversity. Successful interventions have been demonstrated with children, adults, families, communities and within schools, hospitals and industrial and financial institutions.

First, second and third wave approaches

The different approaches to CBT have sometimes been referred to as first, second or third wave (see Hayes, 2004). First wave approaches are those drawn from the behavioural tradition. This includes the influential work of Pavlov, Watson, Rayner, Jones, Wolpe, and Skinner, the subsequent contribution of Eysenck and Martin (1987) and more recently the work of Spiegler (2015).

Second wave approaches represent the cognitive tradition. This includes the principles and methods derived from the work of A. T. Beck and Ellis,

and subsequently the work of J. S. Beck, D. M. Clark, Leahy, Padesky, Persons, and Salkovskis, to name just a few. From classic texts such as Beck et al. (1979) to more recent applications (e.g. CBT for psychosis; see Morrison et al., 2003), this tradition has explored how CBT can be adapted to the needs of an increasingly diverse range of clinical phenomena.

The third wave refers to those approaches which draw upon a range of ideas and create new amalgams of theory to inform practice. Collectively, third wave approaches seek to enhance the effectiveness of the field by capitalising on contextual, functional and experiential strategies of change and through promoting the psychological processes that enable well-being, as opposed to focusing on the reduction of symptoms or the treatment of disorders. Unlike second wave CBT, third wave therapies typically target the processes of thinking rather than specific cognitions. Included in this category of therapies would be mindfulness-based cognitive therapy, compassion focused therapy, acceptance and commitment therapy, dialectical behaviour therapy and metacognitive therapy. These approaches draw upon the work of a wide range of scholars, including Segal, Williams and Teasdale (mindfulness-based approaches), Gilbert (compassion-based approaches), Linehan (dialectical behaviour therapy) and Wells (metacognitive therapy).

Although distinguishing between different waves of CBT has been contested by some (see Hofmann & Asmundson, 2008), for the purposes of this book we find it a helpful device for navigating the rich, diverse and at times conflicting perspectives that inform the field. In particular, and for the purposes of an introductory text, we focus specifically on the first (behavioural) and second (cognitive) traditions as these represent what most would regard as the fundamental underpinnings of the approach.

The historical context of CBT

Behavioural approaches form the first wave of CBT. These have their origins largely within the discipline of experimental psychology and can be traced back to the first psychology department at the University of Leipzig, established in 1879. Here, Wundt developed structured ways to analyse sensory processes, thoughts and reaction times. This early work laid the foundations for creating an understanding of human behaviour through controlled experiments. The main early contributors to what became behavioural therapy lay in the pioneering work of Pavlov and Skinner.

Pavlov's contribution, from the 1890s onwards, lay in the recognition of the role of stimulus in determining behaviour. His most famous experiment involved work with dogs. He discovered that if dogs were presented with food, they will begin to salivate. This is an unconditional stimulus because the effect happens before any learning is introduced. Pavlov demonstrated

that if the experimenter took a neutral stimulus (e.g. the sound of a bell) and paired it with the presentation of food, the dogs learned to associate the sound of the bell with food and so began to salivate to the sound of the bell. This was termed the conditional stimulus. Pavlov later found that this response generalised to other features of the environment, such as a dog being led into the experimental laboratory.

Much of human behaviour is also learned through a process of conditioning in which we learn to associate novel stimuli with familiar ones. In the 1920s, Watson and Rayner began to use this understanding to develop research into human patterns of behaviour, such as anxiety responses. They showed how a fear of a neutral object could be conditioned through pairing it with an object that generated fear (such as a loud noise). Correspondingly, during the 1920s Cover Jones (1924, 1926) conducted a series of experiments that demonstrated how such fears could be directly deconditioned by pairing a pleasant stimulus with the feared one to gradually reduce the fear reaction. She later developed a wide range of interventions to deal with fear responses and was also one of the originators of longitudinal studies of childhood which generated considerable interest in child development.

The relationship between stimulus and response, termed classical conditioning, remains central to behavioural approaches to this day. Therapists working within this tradition consider the behaviour of interest and try to identify what stimulus reliably precedes it: that is, the antecedent.

The other main contribution to behavioural approaches lies in understanding the relationship between behaviour and its consequences. This emerged from a variety of sources but principally from the work of Skinner, who demonstrated that behaviour was shaped and maintained by its consequences. For example, rewarding a behaviour increases the likelihood of its being repeated. This process of operant conditioning provided the gateway to numerous studies and applications in fields such as education and therapy. By the 1970s it was used widely to manage violent behaviour, to promote pro-social behaviour in adolescents, in machine-based learning and on patterns of consumer behaviour. As for classical conditioning, the research base for operant conditioning continues to develop (Staddon & Cerutti, 2003).

At the same time as behaviour therapy was growing in popularity, other scholars became interested in cognition – a perspective that was neglected during the rise of behaviourism. This interest has a long history in the field of philosophy. For example, Emmanuel Kant sought to understand how we perceive the world. He made major contributions to our understanding through recognition of features such as the way our perceptions of the world are filtered through our subjective consciousness. Another philosopher who has proved influential on the development of cognitive approaches is the Greek philosopher Epictetus, who argued that, as human beings, we are distressed not by events but by the views which we take

of those events. Perhaps, however, the most commonly cited influence on CBT is the Greek philosopher Socrates, who taught his students not by providing them with facts but by asking them a series of questions aimed at uncovering inconsistencies in their thinking. By exposing these inconsistencies, and through the application of critical reasoning and logic, he sought to help his students arrive at more robust and reliable conclusions about life's most pressing concerns (see Chapter 4 for how the Socratic method is used in CBT).

The modern use of earlier philosophical ideas developed from the work of Ellis from the 1950s and Beck from the 1960s. Parallel fields which emerged, such as personal construct psychology (Kelly, 1955), symbolic interactionism (Mead, 1932) and social constructionism (McNamee & Gergen, 1992), explored similar issues in the way our perceptions of the world are co-constructed and shape how we interpret what happens to us. The essence of the cognitive tradition was the need to revisit the question of how behaviour might reflect the way we think about the events that happen to us. Hence, rather than a focus on the stimulus response pattern, cognitive theorists looked at how behaviours were shaped by the beliefs we hold and our perceptions of the world, which inform how we interpret our circumstances and choices. While behavioural and cognitive approaches developed as different traditions, there were, during the 1970s, attempts to combine them. Perhaps the most notable example of this was the work of Meichenbaum, who brought practitioners together to share their ideas on applications of behavioural and cognitive approaches and to explore what each could contribute to the other. He later attempted to synthesise these into an integrated approach (Meichenbaum, 1976). In the UK, the British Association for Behavioural Psychotherapy, founded in 1972, subsequently changed its name in 1992 to incorporate cognitive approaches. As interest in the field grew, research on effectiveness followed and demonstrated the value of CBT as an intervention of choice for a range of difficulties (see Roth & Fonagy, 2005). Thus, the family started as an amalgam of behavioural and cognitive therapies but quickly came to incorporate a range of ideas sharing common assumptions. Theoretical and technical developments in both behaviour therapy and cognitive therapy have continued so that, while the origins remain important, our understanding of concepts such as conditioning has evolved.

CBT as an evidence-based intervention

A claim made by CBT therapists, commissioners and increasingly communicated to clients and other stakeholders is that CBT is evidence-based. Many studies have examined this claim, including Roth and Fonagy (2005) as well as national bodies such as the National Institute of Health and

Care Excellence (NICE, 2004a, 2004b, 2011, 2019). The value of CBT and its potential contribution to enhancing the well-being of the population was recognised in England's 'Increasing Access to Psychological Therapies' (IAPT) initiative (Department of Health, 2008). This has led to a significant expansion of the CBT workforce to deliver treatments for a range of common mental health problems. We discuss this further in Chapter 11.

The empirical evidence underpinning the approach has made a persuasive case for why CBT needs to be more widely accessible. While the evidence for the effectiveness of CBT is strong in some cases, it is not effective for all clients with all conditions and the field is not without its critics (Gaudiano, 2008). Nonetheless, claims for specific therapies conducted under controlled conditions are robust. For example, Hofmann et al.'s (2012) review of meta-analytic studies on the efficacy of CBT concluded that the evidence base is strong, particularly for anxiety disorders, but weaker for other problems. More recently, David et al. (2018) repeated the assertion that CBT is effective but highlighted that there is no room for complacency. However, David et al. (2018) see a positive trend in that CBT is an evolving landscape of practice which is committed to seeking evidence and believe that this may encourage a more research-informed approach among other psychotherapeutic traditions. Nevertheless, there are dissenting voices (Goldiamond, 2002).

Fundamental assumptions that underpin CBT

In its approach to understanding clients' problems, CBT typically differentiates predisposing factors from precipitating and perpetuating factors. In other words, the factors implicated in getting a problem going in the first place are not necessarily those that maintain it. These distinctions are evident in the literature. For example, the relationship between patterns of behaviour difficulty and factors including a person's childhood, community, family, socioeconomic status, gender, health and temperament have long been recognised (Rutter, et al., 1976). In addition, early environmental stress and multiple stressors over a period of time have been shown to increase the likelihood of difficulties in later life (Doom & Gunnar, 2015). However, it cannot be inferred that a difficult childhood *causes* subsequent mental health issues. From a CBT perspective, the exploration focuses on the patterns of belief and behaviour that have been learned as a result of those experiences. An additional focus is the current situation and the identification of factors that maintain specific patterns of cognition and behaviour.

The ABC framework provides one useful way of summarising the enquiry that therapist and client undertake. Of particular interest are events which precipitate a behaviour or emotional response, also known as the antecedent (A) and what follows the behaviour (B), also termed the consequence (C).

The idea of exploring the ABC pattern is common within behavioural and cognitive approaches, although there is a difference of emphasis. Specifically, behaviourally-oriented therapists consider antecedents in terms of stimuli that act as triggers and view consequences as potential reinforcers for the behaviour. Behaviours are those actions that can be directly observed. In contrast, cognitively-oriented therapists, while also concerned with antecedents, are interested in uncovering patterns of thinking and the specific cognitions that they trigger. Consequences are likely to be understood as outcomes of thinking patterns or cognitions. Both orientations explore any protective factors, strengths or opportunities that the client brings or that the context creates that could overcome or mitigate the negative effects. Examples of how predisposing, precipitating, perpetuating and protective factors are considered can be found in the subsequent chapters of this book.

Once the relevant patterns are identified it becomes possible to create a formulation that reflects a theoretically-informed understanding of what is happening to generate the issue of concern (see Chapter 10). Any intervention plan that is subsequently developed will take account of the thoughts, feelings or actions that the client wishes to increase and decrease. At times, the client may be hampered by the absence of a repertoire of skills. This is where CBT has developed a range of approaches, such as social skills training and emotion regulation skills, to instil adaptive behaviours. Discussing with the client what patterns they want to increase, decrease or instil is an empowering way of helping them take control of the change process (Lane, 1978, 1990; Welsh Assembly Government, 2012; Bruch, 2015).

Common myths and misconceptions

As we hope we have demonstrated, CBT is a sophisticated, creative and evolving family of therapies that attempts to be responsive to the needs of those who seek psychological support and the changing needs of our society. Despite variations in perspective and method, what all the approaches share is a commitment to evaluating and refining their effectiveness through use of carefully controlled studies and the development of scientific evidence. Nonetheless, CBT has also attracted myths and misconceptions. Some of the most espoused myths are those that we list below.

1. CBT methods are mechanistic, cold and controlling

While CBT has developed and draws upon a diverse range of techniques to support people in making changes, these are always applied in the context of a warm, supportive and collaborative working relationship. A review of the work of contemporary CBT scholars evidences the emphasis that is placed on the importance of building rapport and creating an effective

working alliance. As Meichenbaum (1976), an early developer of CBT, Meyer (see Bruch, 2015), a pioneer of behavioural approaches, and Beck et al. (1979), who pioneered cognitive therapy, have all highlighted, the relationship between therapist and client is central to the work.

2. Cognitive methods are about treating symptoms not the person

CBT is a biopsychosocial approach to intervention; that is, it is concerned with the body, our emotions, the way that we make sense of our worlds and the interpersonal contexts in which people live. There may be times when the agreed focus of therapy is one of targeting a specific mental health disorder (subsequent chapters in this book provide some examples of this), but the notion that CBT is a 'symptom fix' is misplaced. While it was a common assumption among critics in the early days, as CBT has expanded its approach this myth has become less tenable.

3. CBT fits clients to protocols rather than tailoring its approach to the client

It is sometimes claimed that CBT simply applies protocols to disorders rather than being concerned with the client's history, relationships and context. Where they exist, protocols can provide valuable guidance to therapists on what approaches might work best, but these must always be matched to the client. The application of a protocol without due reference to the individual client would not be considered good practice.

4. CBT ignores the client's past and only focuses on the present

The difference between CBT and some other therapeutic modalities is the approach to the past. For the CBT therapist, the past is of interest to the extent that the client's learning history predisposes them to certain patterns of response rather than others. The past is not explored and worked through extensively in order to gain insight, as happens in psychoanalytic methods. However, restructuring problematic aspects of the past happens when therapists work with clients' core belief and schema, or in the context of long-term client issues such as chronic low self-esteem, interpersonal problems and personality disorders. Predisposing factors do, therefore, matter as they help make sense of the person, their history and the contexts in which they have learned how to think, feel and act.

5. The approach takes away the client's agency

CBT is collaborative and works with the client to build a shared understanding of the issues that need to be addressed and a plan to intervene which involves creativity and input from the client. The agency of the client is central to progress and any approach which fails to build on the client's own commitment to change is unlikely to succeed.

6. CBT is limited to the current evidence and so cannot help clients presenting with complex or unique issues

CBT strives to be evidence-based and its practitioners will always seek research to inform the work that they undertake with clients. However, CBT also draws upon experimental, hypothesis-driven approaches. Where there is no comprehensive evidence-base on which to draw, the client and therapist work together to create experiments to explore likely factors of influence that could be modified. In this way complex conditions can be examined and the unique learning history of the client incorporated into the work.

7. CBT is concerned with positive thinking

A particularly common myth is that CBT aims to eliminate negative thinking and help clients 'think positively'. Negative thinking is sometimes an appropriate and adaptive response to the situation in which we find ourselves. If an event occurs which is distressing, the ability to perceive its negative aspects and to experience the negative feelings that go with it are important parts of learning and growing. Negative thoughts can, when adaptive, serve an important self-corrective and at times protective function. Equally, positive thinking – if not tempered by a realistic evaluation of oneself and one's circumstances – can be detrimental. For example, excessive self-belief in a health care professional might result in the assumption that "I'm great at what I do, so I can take short-cuts", resulting in a failure to consider the scientific basis for their decision-making. Unfettered positivity is, therefore, likely to lead to rash decisions, inappropriate risk-taking and poor judgement that has the potential to harm others as well as ourselves.

What therapists are aiming for, then, is *wise* and *flexible* thinking. CBT seeks to empower clients by encouraging them to better understand the way in which they are making sense of the world, identify ways in which their current cognitive stance is proving unhelpful, and broaden their perspective to consider new ways of responding to their circumstances and needs.

Conclusion

CBT is a family of therapies drawn from distinct traditions yet united by a common set of foundational assumptions. Chosen with care it is a powerful form of intervention. Although it is beyond the scope of this chapter to provide more than an introduction to the different therapies within CBT, the main message is that the theory and practice of CBT is a rich, evolving and dynamic terrain in which many ideas are present. These ideas are sometimes seen as being in conflict and sometimes represented as a collaboration but, collectively, they provide many concepts and methods that therapists and clients can draw upon to enable change.

The contexts in which CBT has been applied are highly diverse and include therapy, school-based interventions, parent training, organisational team development and sports science. It is not as is sometimes asserted by its detractors a cold and mechanistic therapy, but rather one based on collaboration which emphasises clients' own agency in bringing about change. As we shall see in subsequent chapters, the application of these ideas and the techniques that they have generated enable clients to become their own therapists to address not just current but also future concerns. This is a sophisticated and long-standing framework for practice.

Reflective Activity: Getting the most from this book

Think about what you most want to gain from reading this book. As you read through each chapter, starting with this one, you might find it helpful to consider your responses to the following questions:

- What did I learn?
- What, if anything, surprised me?
- Were any ideas that I held about CBT confirmed or challenged?
- Having gained an initial sense of the book from this opening chapter, what now is my purpose in reading it? How will I know if that purpose is met?

We recommend that you keep a record of your reflections as you work through the book, noting specifically any ways in which your understanding of CBT changes.



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Kennerley, H., Kirk, J., & Westbrook, D. (2017). *An introduction to cognitive behaviour Therapy* (3rd ed.). London: SAGE.