

9

YOUR BASIC CBT 'TOOLKIT'

Every CBT therapist will build a versatile 'toolkit' comprising generic and transdiagnostic strategies. These will comprise first principles of CBT and highly specific techniques.

I've used the term 'toolkit', but as Beck and colleagues remind us (Hofmann, Asmundson & Beck, 2013), CBT is much more than a collection of techniques and strategies, and CBT therapists are much more than technicians. We carefully select particular strategies in response to a psychological understanding of a person's problems (a formulation), and we do this in an empirical fashion (developing and testing hypotheses and collecting data for review).

We are the tourist who understands the culture and speaks the language, rather than the one who just gets by with a phrase book.

FUNDAMENTAL TOOLS

Many CBT techniques are truly transdiagnostic, fit for purpose for a number of disorders. Thus, you will have a set of skills that will stand you in good stead across a range of psychological problems. Most fundamentally, you will know how to *establish a working alliance* (Chapter 2) and that alone can be therapeutic for some patients. Just as important, you can assess problems and build a *collaborative conceptualisation* of a person's difficulties, creating a framework that embraces aetiology and maintaining cycles (Chapter 5). In doing this you are introducing *psychoeducation* and you will be able to judge if a patient's problem is appropriate for CBT and if indeed your patient is open to CBT at this time. Crucially, you can *identify vicious cycles* or 'traps' that will maintain difficulties and also direct you towards interventions. In addition you are spotting *virtuous cycles* of strengths, resources and coping skills.

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Some of the ‘traps’ will be driven by cognitive factors – cognitive biases, intrusive images, automatic thoughts and core beliefs – and you are now in a position to identify these. Similarly, you can identify the behavioural drivers: avoidance, inactivity, reassurance-seeking and so on.

By now you know how to help patients monitor their difficulties and compile relevant information (e.g. using a thought record), so that the elements of the traps can be detailed. In doing so you make the generic vicious cycle bespoke, and also detailing the traps opens up a world of intervention possibilities because each ‘staging point’ in a vicious cycle points to possible strategies. For example:

Leone heard that there was a department party at the end of the month, and she felt scared. ‘What if I go and no-one wants to talk? No-one will want to talk with me. What if I don’t go and people think badly of me? Either way I’m a useless failure. Two weeks to go – I can’t stand this waiting. I need a drink.’

Here the generic cycle has been personalised with Leone’s particular experience and now a tailored intervention can be devised. But this must be informed by what we know of

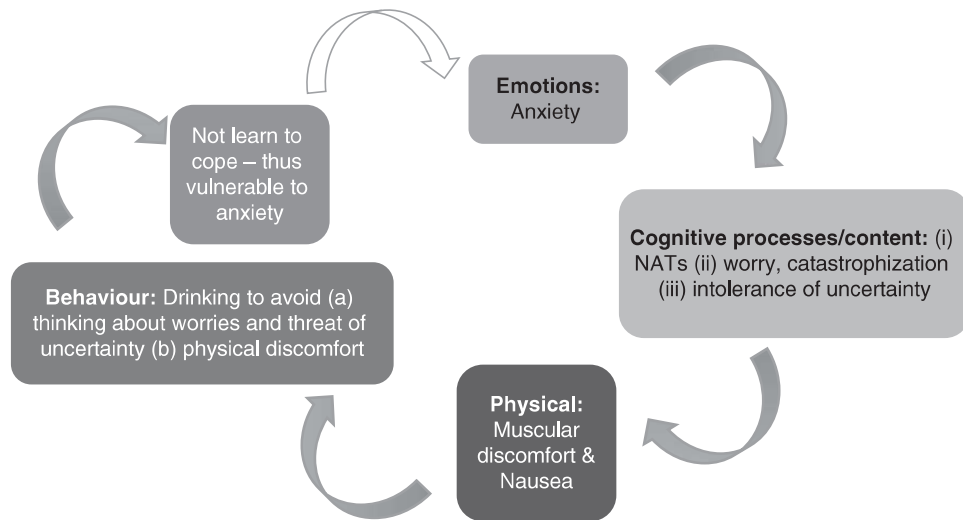


Figure 9.1 Leone’s anxiety trap

best practice. For example, if we look at the *cognitive processes/content* element of the trap, there are many options for moving forward. We could focus on NATs, helping Leone identify the cognitive biases in the thoughts: 'No-one will want to talk with me/I'm a useless failure.' Or we could systematically review them using a thought record, or we could use metaphor, asking her to consider what her best friend would say to her, or we could devise a survey whereby she gathered information from friends to test her views. The choice will be determined by the stage of therapy, what research tells us and patient resources. We could also explore the metacognitions associated with worry, or we could teach distraction so that Leone could opt to put her worries to one side, we could help her develop her use of problem-solving skills to better resolve her worry – what we wouldn't do is focus on the content of the worry and we wouldn't encourage distraction if Leone used this as an SSB.

As you go through this chapter, look back at the trap and consider your options to help Leone manage the problem cognitions, physical symptoms or the unhelpful behaviours.

You also know how to guide patients in *decentering* when distressed and in *reviewing key cognitions*, and if necessary, testing these via *behavioural experiments*. You know how to progress to *problem-solving* when that is most appropriate. You have many talents.

Crucially, you can use Socratic enquiry to review what a patient concludes from their new experience and how they feel. In this way you check that the techniques are being used as coping strategies and not as safety-seeking behaviours, and that the outcome is targeting relevant affect and is not simply an intellectual exercise.

There is even more in the CBT toolkit. Below is a collection of particularly versatile techniques.

Physical techniques

This family of strategies includes controlled breathing and relaxation, but physical strategies do not just focus on calming, they also include applied tension and exercise for those times when getting active or raising blood pressure is necessary.

These physical techniques can be invaluable in breaking free of traps driven by:

- *excessive tension and over-breathing* – e.g. in anxiety disorders such as panic disorder and generalised anxiety disorder, or in anger management problems;
- *a lack of tension and lowered blood pressure* – e.g. in blood phobia;
- *inactivity* – e.g. in depression.

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Controlled breathing and relaxation

This section presents an overview of each of these approaches, but you can also download a script for guiding patients through breathing and relaxation exercises by going to the OCTC webpage at www.octc.co.uk/wp-content/uploads/2016/07/Relaxation-scripts.pdf.

Breathing might seem like a strange skill to teach as we can all breathe, but controlled breathing is a technique that comes into play when a person over-breathes or *hyperventilates*. We tend to breathe more rapidly when we are stressed or exercising and this is not troublesome in the short term, in fact rapid breathing provides muscles with oxygen to prepare the body for action. However, continued rapid breathing can cause physical discomforts, such as tingling face and hands, muscle tremour or pain, lightheadedness, breathing difficulties. Understandably, this can be frightening and therefore heighten anxiety – a simple but powerful trap (see Figure 9.2).

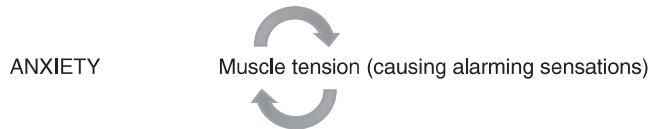
Fortunately, it is relatively easy to learn how to counter over-breathing and break out of the trap. Patients simply need to respond to hyperventilation by respiring gently and evenly (preferably nasally), filling the lungs, before exhaling slowly. This avoids the ‘shallow breathing’ (breathing from the upper chest alone) or gulping that can actually worsen hyperventilation. In the early stages we would encourage patients to lie or sit whilst getting used to the sensations of controlled breathing. Once this rhythmic respiration is comfortable and familiar, they can try it in less relaxing settings such as when walking through town or sitting in a cinema etc. As with many coping strategies, the skill develops with practice, so the more repetitions the better.

Once controlled breathing can be used at will, it can be brought into play to break the cycle of tension and over-breathing.

Not only do we tend to hyperventilate when we are stressed or afraid, but also the muscles in our bodies tense. This is an automatic reaction, perfectly normal, and it prepares us for action. But in excess this too can cause uncomfortable sensations such as a headache, neck, shoulder or chest pain, breathing problems, trembling, a racing heart, churning stomach, tingling in the hands and face. As you might expect, any of these sensations can be worrying and could therefore increase muscular tension – another powerful trap (see Figure 9.3).



Figure 9.2

**Figure 9.3**

An effective way of managing bodily tension is through physical relaxation. Relaxing is more than sitting in front of the television or having a hobby (although these recreations are important too). *Really* relaxing requires the skill of reducing unnecessary physical tension whenever necessary and in a variety of situations.

This skill does not necessarily come easily and it needs to be practised. Like controlled breathing, it is often best learnt by progressing through a series of structured exercises. Usually we begin with some general guidelines advising patients to plan and evaluate their relaxation practice: deciding when and where will be quiet and comfortable. All exercises begin with a breathing check to ensure even and rhythmic respiration and they end with a gentle resuming of normal activities.

Then we introduce a series of routines designed to teach relaxation step by step. Typically, there are four stages, but this can be adapted to the person.

Stage 1: Systematic muscular relaxation

These exercises require a person to tighten and then relax muscle groups within the body in a systematic fashion. Usually, instructions are given to (gently) tense and then relax the feet, lower legs, upper legs, torso, arms, shoulders and neck, face.

The routine helps the very tense begin to distinguish between taut and relaxed muscles and to learn to recognise muscular tension and relax in response to this. Repeated practice is necessary but once relaxation is reliably achieved, Stage 2 can be introduced.

Stage 2: Short systematic relaxation

Stage 1 can be shortened by simply missing out the 'tense' stage. This modified exercise needs to be rehearsed, and when it is effective it can be adapted for use at other times and in other places (e.g. in a less quiet room) so that the skill is increasingly adapted to real life.

Stage 3: Simple relaxation routine

This is an even shorter exercise, suitable for those who can achieve a relaxed state with minimal guidance. It requires a person to sit in a comfortable position, allowing their body to

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become heavy and their breathing to become gentle and regular. On each in-breath, a soothing word or mental picture is brought to mind, and on each out-breath, the sense of relaxation and heaviness is intensified.

Stage 4: Cued relaxation

Once stages 1 to 3 become effective the relaxation skills can be cued throughout the day and not just practised at designated relaxation times. In response to a prompt (e.g. a discreet alarm on a phone or a watch) a person simply:

- drops their shoulders;
- untenses muscles in the body;
- checks their breathing;
- relaxes;
- moves on.

Thus, relaxation becomes a portable skill to be used when needed.

It can be helpful to keep a record as it encourages reflective review and ensures that progress does not go unnoted (see Table 9.1 for a typical relaxation record).

It is only natural to have the odd occasion when it is not possible to achieve a relaxed state, and the usual suspects are trying too hard, not being in a place conducive to relaxing, not being well rehearsed enough, catching the hyperventilation or tension too late for effective management. When a patient struggles simply help them to review what got in the way of easy relaxation and then shift to planning how to overcome obstacles in the future.

Although most patients benefit from beginning with the lengthy exercise and gradually reducing it, some people would prefer to start with the simple routine.

George had been abused as a child and now feared letting down his guard, so his therapist suggested starting with the simple relaxation exercise that allowed him to remain sitting with his eyes open. In this way George remained aware of what was happening in his environment and thus he felt in control. As he grew more confident that it was safe for him to relax, his therapist encouraged him to try the deeper relaxation exercises.

Table 9.1 (Continued)

Table 9.1 Relaxation record

Relaxation record

Monitor your progress by rating your level of relaxation before and after carrying out a relaxation exercise. You can use the following scale:

Not relaxed Tense				Moderately relaxed			Very relaxed
0	1	2	3	4	5	6	7 8
Date/Time	Type of exercise	Rating before	Rating after	Notes			
Wed 10am	Systematic Muscular Relaxation	7	3	Quite helpful – better than last time (I think I might be getting the hang of it). Did notice the cold so I'll use a blanket next time I'm lying down to relax.			
Sat 6pm	Systematic Muscular Relaxation	7	7	What bad timing: TV blaring in next room, me thinking about getting supper rather than let my worries go. I will plan better next time – I realise that I can't just squeeze this into a busy day.			
Sun 11am	Short Systematic Relaxation	7	2	I'm getting better at this. I could really let my worries and tension drift away today as I sat in the easy chair. All the practice pays off.			
Wed noon	Simple relaxation	6	4	Sitting at home. Quite easy to do this after all the practice with the longer exercises. It felt natural and it helped that I had lovely memories of walking along the beach on our last holiday.			
Sat 11am	Simple relaxation	8	4	Tense in the house because of all the bickering. Went up to my bedroom for a few minutes and was able to get calm and then face the family again			
Fri 8 pm	Cued relaxation	6	4	Needed to relax before dinner in a public place – went to loo and spent a minute letting the tension leave my body while I got my breathing nice and smooth. It took the edge off my tension.			

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Applied tension and exercise

Sometimes problems occur because of low blood pressure. We see this, for example, in people who grow faint when they see, or anticipate seeing, blood or in those whose post-traumatic reaction is one of faint rather than fight or flight.

Janice had become quite reclusive because she disliked the woozy feeling she sometimes experienced when she went out. She feared that she might faint and hurt or embarrass herself so now she tended to stay at home. Her doctor explained that she had low blood pressure, like other members of her family, and that she could learn to tense her muscles, raise her blood pressure (BP) and manage the unpleasant sensations.

Phil had always felt faint on seeing blood and he'd become quite phobic about blood and even needles. His therapist explained that it is normal for BP to drop when we see blood and this could easily cause feelings of faintness. To counter this, she taught Phil to use applied tension, which quite quickly restored his confidence and the extreme fear disappeared.

Teaching applied tension is simply a matter of adapting the exercises above so that the focus is only on tensing muscles and developing the skill of doing this even when feeling woozy. Generally, this is combined with controlled breathing to minimise the likelihood of dizziness from hyperventilation (Gilchrist & Ditto, 2012).

Finally, physical exercise can play an important part in a patient's recovery. It has long been established that physical activity helps people break free from inactivity that fuels low mood or anxieties by reducing a sense of achievement and purposefulness. Physical activity also stimulates the brain to produce some of the 'feel-good' bio-chemicals (Kvam, Lykkedrang Kleppe, Nordhus & Hovland., 2016; Mikkelsen, Stojanovska, Polenakovic, Bosevski & Apostolopoulos, 2017).

Thus, the cycle is broken (see Figure 9.4).

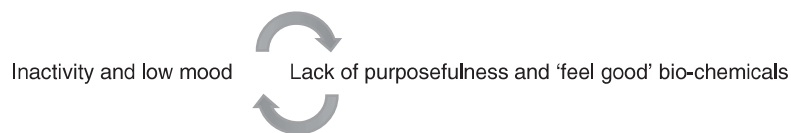


Figure 9.4

A very well-established technique for increasing physical activity is Behavioural Activation (BA), which uses highly-structured activity scheduling and review (see Chapter 8). A simpler intervention is simply taking steps to incorporate regular exercise and purposeful activity into daily life – and monitoring the impact of this, of course.

Kyle had grown less active as his mood dipped. Through behavioural monitoring and behavioural experiment, he realised that even small increases in his social activity raised his spirits, and doing even minor tasks around the house bolstered his sense of worth.

Simple cognitive techniques

As you have seen, in CBT we use cognitive review and testing (see Chapters 7 and 8), but we also use other, relatively simple cognitive techniques.

Decentring

A fundamental cognitive technique is *decentring*, the action of standing back and seeing a thought or image as just that – a mental event, not necessarily a truth. We can also decentre and consider a feeling as just a feeling.

For some this detachment and review is enough to get a new and less distressing perspective. For others, decentring coupled with recognising cognitive bias (see Chapter 1) does the trick.

A self-critical thought instantly brought down Harvey's mood and then he remembered to mentally stand back from the cognition and label it 'just a thought.' The thought instantly had less emotional impact even though it remained an unpleasant notion.

Moira's anxiety rose: 'He thinks I'm an absolute fool.' Then she took a moment to decentre, feel calmer and then rethink. She concluded 'Hang on, I'm mind reading again and jumping to a conclusion. Actually, I've no idea what he's thinking.' She immediately felt some relief.

Addie usually concluded 'I feel scared so something must be wrong.' Decentring led him in a different direction. He learnt to drop his shoulders, breathe evenly, and say 'I feel scared but that's just

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a feeling. A feeling is not a fact.' By doing this he calmed himself and began to build a database, which supported the notion that feeling an emotion could be independent of, or even at odds with, reality.

Distraction

A more demanding yet still conceptually simple strategy is distraction. Based on the premise that we can only fully concentrate on one thing at once, distraction helps to reduce our distress by shifting our attention to something neutral or positive. This means it is possible to break free of the trap of negative cognitions (thoughts or images) fueling our negative mood, which in turn drives negative thinking (see Figure 9.5).

The key to successful distraction lies in:

- devising tasks that grab attention (use your patients' interests);
- keeping them specific – vague tasks tends not to be so effective;
- having several strategies for different settings because not all techniques will fit all settings (see Table 9.2 below);
- practice, practice, practice.

There are three basic distraction techniques.

1. Physical exercise

Keeping active when distressed so that it is difficult to dwell on upsetting thoughts. The simpler the activity the easier it can be to engage, so don't underestimate the impact of a short walk or clearing out a cupboard or even organising a handbag or briefcase. Your patients will need to experiment to find a few physical activities that will work for them in different situations – going jogging is not always possible!



Figure 9.5

Table 9.2 Distraction techniques

Anxiety provoking situation(s)	Suitable distraction technique
Sitting in the bus shelter	Read car number plates Listen to soothing music through ear buds Attend to my breathing and talk myself through a simple relaxation exercise
Waiting in the hospital	Review my photographs on my phone Play Solitaire on phone Read my novel Watch others come and go and try to guess their occupation
At home, worrying about my health	Go for a run Do some gardening (favourite hobby) Clear out the airing cupboard Watch Gardening programmes on TV/DVD
In bed at night, frightened	Do a long relaxation exercise Remember my recent visit to a National Trust Garden in detail, remembering the smells and the sounds as I recall walking through the gardens

2. Refocusing

Paying great attention to things around, such as: counting the number of men or women with blonde or short hair; looking for certain objects in a shop window; studying the details of someone's outfit or a picture; reading the small print on tins in the supermarket; noticing the smells and sounds in the environment. The task doesn't need to be sophisticated but it does need to be absorbing, and the more detailed the task the more distracting it will be.

3. Mental exercise

This requires more creativity and mental effort. It might involve reciting some poetry or a piece of music, recalling a favourite holiday trip in detail, practising mental arithmetic, studying someone nearby and trying to guess what they do, dwelling on an imaginary scene and so on. The latter are more effective if they come alive with colour, sounds and texture, and if they suit the patient's preferences. There is no point in dwelling on a picture of a sun-soaked beach if we hate the sea and sunburn easily, or if our real love is skiing. A better mental picture would be of a snow-covered mountainside and a journey down a particularly satisfying slope.

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Strategies need to be practised and refined and even so there will be times when they are not very effective. This might be for several reasons:

- More practice is needed.
- The technique didn't fit the situation.
- Initial stress levels were very high or the situation itself was stressing.
- Distraction is used as a safety-seeking behaviour (see Salkovskis, Clark, Hackmann, Wells and Gelder, 1999 for a description). Do always debrief to ensure that the patient appreciates success as an indication of them being able to take command of a situation so that their confidence grows.

Simple imagery work

Problem images can be identified in virtually all the disorders that we work with and much has been written on imagery work since the inception of CBT. An excellent reference for imagery work is *Imagery in cognitive therapy* written by Hackmann, Bennett-Levy and Holmes (2011). This is a comprehensive handbook that goes beyond basic CBT, but the authors remind us that very simple visual techniques can still make a difference. Using imagery does not need to be challenging for therapist or patient.

Rehearsing in imagination has been shown to increase the perceived plausibility of an event happening (Szpunar and Schacter, 2013), which means that it can enhance confidence, and it has been shown that mental images can evoke similar physiological and emotional responses to the real thing (Pearson, Clifford & Tong, 2008). Thus, we can usefully integrate imagery into therapy in order to:

- *build confidence*, step by step, in those not yet ready to face challenges in real life, e.g. a patient with a fear of snakes holding increasingly challenging mental images of snakes as a prelude to visiting the local zoo and handling one;
- *substitute* when it is not possible to practise in real life, e.g. someone with a fear of flying repeatedly imagining themselves travelling by plane – for financial and practical reasons it would not have been possible to repeat this experience in real life;
- *prepare* to take on a challenge, e.g. a patient imagining themselves walking into a public area feeling calm – reviewing this image helped them to feel calmer and more confident when they took on a social task for real.

We have already seen how mental images can enhance distraction; Beck et al. refer to using 'visual imagery as a diversion from dysphoria' back in 1979 (p. 172) and Beck and colleagues describe many simple imagery techniques for managing anxiety disorders (1985). More

recently there has been a focus on image management in post-traumatic conditions (e.g. Ehlers and Clark, 2000) and you can download an OCTC document that summarises understanding traumatic intrusions from www.octc.co.uk/wp-content/uploads/2016/10/Understanding-traumatic-intrusions-OCTC-practical-guide.pdf.

Some problem visualisations will diminish simply as a result of understanding and formulating them (see Chapter 5) while others will persist. Persistent images can be managed in several ways.

Distraction

Alana struggled with the urge to drink – the visual image of a glass of wine and the bodily sensation of its cool taste and relaxing effect played on her mind as she walked through the shops. She was so tempted. Then she shifted her attention to the lyrics of a song that she knew well, and recalling the song not only displaced the image but also cheered her and reduced her stress.

Holding the image and manipulating it to change its emotional impact

Brandon's memory of being threatened at work kept returning. It was vivid and disturbing, but he learnt to accept that it might come back and when it did, he imagined the customer who threatened him shrinking into a child and the knife that he held turning into a harmless soft toy. Then the child was led away by a kindly police officer. Brandon noted that his feelings changed, the intense fear subsided, and he felt safe. Soon the images reduced in frequency and intensity.

Charlotte was low and hopeless about ever losing weight and she had an intrusive image of herself as an overweight unattractive person that she called 'the repellant blob'. This worsened her mood and made her more likely to comfort eat. When the image next came to mind, she tried to fast forward to a time where the hard work of dieting and exercising had paid off, and she 'saw' herself at her goal weight doing the things that she'd been able to do before her weight gain. Holding this view of the future in mind gave her hope and motivated her.

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Rerunning the image, reviewing and updating it

Sharya wanted to join in college events, but she was unconfident and the thought of being with others was always accompanied by an image of herself lost for words, blushing and feeling unbearably foolish. The emotional impact of this inhibited her. However, she learnt to mentally rerun this image, but she changed the content in line with what she knew about herself, namely she was articulate in class, she was well-informed about current affairs, and she had learnt the art of relaxation. Thus, she was able to change the scene to one where she stood with others, calm and relaxed. She imagined that she was in conversation and engaging others by sharing her perspective on the day's headlines.

When Thom was low he felt lonely and emotionally flat. He sometimes had the image of quietly driving off to a remote layby and taking an overdose. He knew that this was dangerous thinking and he tried to counter it by imagining the drive, but instead he remembered his friendships and imagined his best friend with him touring the countryside, paying attention to the beautiful aspects of the world and reminding himself that he was not alone, that he could feel pleasure, that there was reason to live and that these low periods usually passed.

Devising a new ending so that the story arc of the image is bearable

Di's childhood was unhappy, and she had shadowy memories of being afraid and being hurt. She did not yet want to dwell on those memories, but she did want some relief from them. Her therapist asked her how she felt when these images intruded, and Di reported feeling vulnerable and afraid. Her therapist asked her how she needed to feel in order to cope. Di wanted to feel strong and confident, so her therapist suggested that she consider how the shadowy images might be transformed. Di described imagining herself rising up like a superhero and raising her hand, sending the shadows billowing back. As they disappeared, she saw and felt sunlight and realised that she was standing tall and strong. She felt safe. She rehearsed what she called her 'superhero' scenario and used it each time the shadowy image troubled her. She grew less and less fearful of the dark image and eventually it ceased to bother her. She felt in control.

As with all CBT strategies, distracting and alternative images need to be practised and refined, otherwise they will be less effective in combatting problem images, and of course therapists need to check that imagery techniques are not being used as SSBs. So always review what your patient is learning from the exercise – if the exercise is therapeutic then you should hear that they are enabled by it, not superstitiously clinging to it.

A final note about imagery work – *it should not be undertaken lightly*. Images can be very emotionally evocative, so you should always check that your patient is emotionally robust enough to engage in imagery work. In the examples above, Di was not able to focus on the frightening images per se, that would have overwhelmed her, but she was able to focus on developing a constructive coping scenario. If imagery is particularly traumatic or dangerous in content (e.g. vivid images of harming self or others), then safety needs to be prioritised and breaking confidentiality needs to be considered. An important caution was also raised by Arntz and Weertman in 1999. They advised that therapists working with problem images that appear to be recollections '*must be aware of the (re)constructive processes of memory*' (p. 717). Memory formation and recall is a complex series of processes and it is not infallible. Professor Alan Baddeley's (2004) book, *Your memory: a user's guide*, is an excellent resource for those who need a reminder of the reliability (and unreliability) of memory and the dangers of distorting recollection.

Invaluable generic techniques

There are a number of versatile strategies that are not limited to CBT but which can usefully be incorporated into a CBT approach. Top of my list are assertiveness training and problem solving.

Assertiveness training

Arguably the most fundamental of the social skills, assertiveness lays the foundation for so much of our therapeutic work: anger management, social confidence building, relationship issues, and more. I couldn't do my job without this basic procedure.

In a recent article, Speed, Goldstein and Goldfried (2018) review what they call 'a forgotten evidence-based treatment', reminding us that it has been part of the psychotherapist repertoire since the 1940s. It is recommended by Beck et al. (1979) and has a very persuasive empirical record.

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For those who need a refresher on the basics of assertiveness training, the OCTC has a downloadable overview at www.octc.co.uk/wp-content/uploads/2016/10/Assertiveness-OCTC-practical-guide.pdf.

Problem-solving

Problem-solving is a long-established therapeutic technique (D’Zurilla & Goldfried, 1971), particularly in depression (Cuijpers, de Wit, Kleiboer, Karyotaki & Ebert, 2018), and it has been shown to be effective even in a very brief format (Catalan, Gath, Anastasiades & Bond, 1991). Understandably then, Beck and colleagues (1979) remind us that problem-solving is a valuable technique in our CBT toolkit.

Socratic enquiry helps us guide a patient through the stages of:

- defining the problem;
- brainstorming multiple solutions;
- planning to put a solution into action;
- devising contingency plans;
- reviewing the outcome.

Problem-solving has been associated with reduced relapse in several conditions, such as depression (Scott, 2000), obesity (Murawski et al., 2009), and alcohol misuse (Demirbas, Ilhan & Dogan, 2012), so it’s worth reviewing a patient’s skill prior to discharge.

Again, for those needing a quick refresher, the OCTC has a downloadable document at www.octc.co.uk/wp-content/uploads/2019/11/Problem-Solving-OCTC-practical-guide-.pdf.

While problem-solving is a valuable technique when prompt action is needed, remember that it is always better to plan well in advance if possible. So do discourage patients from putting things off.

Relapse management

Speaking of putting things off, long before discharge a patient should begin learning the skill of relapse management. This is the ability to cope with setbacks by understanding them (i.e. formulating them), learning from them (i.e. reflecting), and moving forward (i.e. problem solving). The term ‘management’ is often more accurate than ‘prevention’ as setbacks are common – and even constructive if a person knows how to learn from them.

This is just a brief overview of Relapse Management; a more detailed document can be found on the OCTC website at www.octc.co.uk/wp-content/uploads/2016/07/Relapse-management-2.pdf.

The pioneers of relapse work were Marlatt and Gordon (1985) who developed sophisticated cognitive behavioural methods that are still worth revisiting. However, the essence of relapse management can be captured in three questions that are simple enough to be brought to mind even if someone is distressed:

1. Why is this setback understandable?
2. What have I learnt from it?
3. What will I now do differently?

You can first work through these questions in session, helping your patients learn to decentre and grow familiar with the questions that they can later use in the field.

Jo sometimes binged. One evening she bought quite large quantities of foods and wine, went home alone and consumed most of it. This would usually have marked the beginning of a significant decline. She would have woken the next day in discomfort, would have concluded that she was a hopeless failure and her mood would certainly have been depressed. As a 'hopeless failure' she would have felt powerless to resist the urge to have a numbing glass of wine and/or comfort-eat. However, on this occasion, she decentred and asked:

- *How can I make sense of this lapse?* She appreciated that she'd been stressed at work for several days but had kept pushing on in order not to think about a troubled relationship. In addition, she'd resumed an old habit of starving throughout the day in an attempt to lose weight. Once she had reflected on the situation, she was able to say 'It's no wonder that I fell off the wagon. Not only was I stressed to breaking point, but I also set myself up for a binge by not eating during the day.'
- *What have I learnt from it?* 'For me, it's dangerous to starve as a means of weight control or to try to take control of my emotions– it backfires. Also, I need to keep a check on my stress level: when it gets too high, I'm so vulnerable to buying that bottle of wine and comfort-eating.'
- *With hindsight, what will I now do differently?* 'Hard as it is, I would try to eat sensibly during the day without starving. Looking back, I made a mistake in trying to pretend that I did not have problems in my relationship and instead throwing myself into work as a

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distraction. If I had that time over again, I would acknowledge my problems, maybe even talk to someone about them rather than ignoring them. I could probably have talked with my brother – he always says that I should. Next time I will.'

This gives Jo more insight into her vulnerabilities as well as a strategy for the future. She will have other setbacks and she can learn from these to refine her personal coping methods.

Relapse management is often enhanced by:

1. *Addressing dichotomous thinking.* People often think in terms of being in *Control* OR *Relapse*. This means that one slip is perceived as failure and then the chance of spiralling into a relapse is high. Better to be able to recognise all the stages en route to actual relapse (see Figure 9.6).

This perspective means that a person is more likely to see a slip or setback as a temporary aberration – one that could be managed.

2. *Being risk sensitive.* Over time people get better at addressing the questions:
 - 'When will I be at risk of this happening?'
 - 'What are the signs?'
 - 'What could I do to avoid losing control?'
 - 'What could I do if I did lose control (damage limitation)?'

In this way 'early warning signs' can be detected, and patients can try to avert trouble, whilst still having a well-considered back-up plan. These headings can form the basis of a *blueprint* (see Chapter 4).

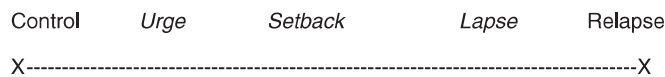


Figure 9.6

Table 9.3 Specific CBT techniques

Specific CBT technique	
Thought records	Chapter 7
Data logs	Chapter 7
Downward arrowing	Chapter 7
Responsibility Pie	Chapter 7
Continuum technique	Chapter 7
Worry decision-making tree	Chapter 7
Cost–benefit matrices	<i>Chapter 4</i>
Theory A/Theory B	<i>Chapter 8</i>
Activity schedule	Chapter 8
Graded practice	Chapter 8

SPECIFIC CBT TECHNIQUES

CBT clinicians and researchers have developed many CBT-specific techniques, and several were introduced in earlier chapters (see Table 9.3).

Although some strategies were devised to be problem-specific you will find that several are transdiagnostic and thus deserve a place in your basic toolkit.

SUMMARY

- CBT therapists are familiar with a wide range of coping techniques, many of which are transdiagnostic. This enables us to be flexible and respond to patient need.
- Techniques embrace cognitive, behavioural and physical strategies.
- Some are specific within CBT, others are generic within CBT, others are generic across psychotherapies. Our formulations will guide us in best use of strategies.
- By the end of treatment, patients need to know what works for them (the blueprint is a reminder) and how to manage relapse.

REFLECTION & ACTION

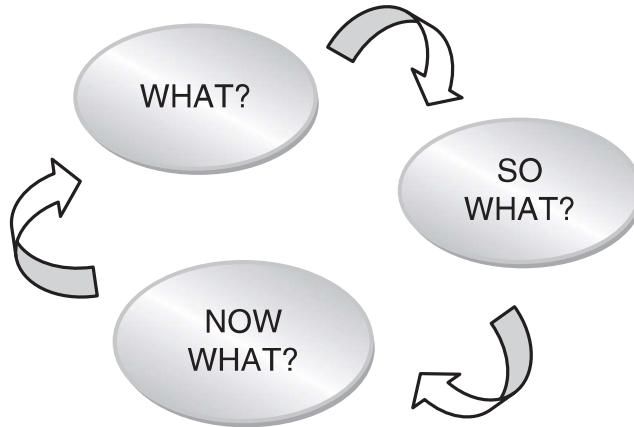


Figure 9.7

WHAT are you taking away from this chapter? What teaching points resonate with you?

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SO WHAT? What significance do these points have – how do they relate to your previous learning or views? Do they challenge your former opinions? Have you gleaned new ideas for helping patients or indeed looking after your own needs?

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NOW WHAT? This is all very well but how will you take this forward? What are you now going to do differently? Make a commitment with yourself to follow through on at least one of your new ideas.

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