CHAPTER 1

Introduction

Overview

This chapter will examine the development and future of cognitive–behavioural therapy (CBT). Starting with the ideas of behaviourism and the development of conditioning theory, it moves to examine the exposure theory and its application in clinical practice. This sets the groundwork for the concept of pragmatic treatments based on direct clinical observations rather than being guided purely by theoretical models. Mention will be made of other third wave treatments such as mindfulness, behavioural activation, dialectical behaviour therapy (DBT), acceptance and commitment therapy and integrative couple therapy, the cognitive–behavioural analysis system of psychotherapy and functional analytic psychotherapy. Finally, there is a summary concerning research and CBT and a look towards possible future developments.

The development of CBT: history, theory and practice

First generation therapies

Behaviourism arose at the beginning of the 20th century. Its central tenet is that all organisms react to the external environment with a variety of behaviours. These behaviours are learnt and are in response to reinforcement, and so it follows that psychological and psychiatric conditions are seen largely as being due to maladaptive learnt behaviour in response to the environment.

Key people who developed the theories of behaviourism were:

- Ivan Pavlov (classical conditioning; Pavlov, 1927)
- Edward Lee Thorndike (pioneer of using animals in psychological experiments; Thorndike, 1933)
- John Broadus Watson (animal studies and also genesis of phobias in humans – the 'Little Albert' experiment; Watson, 1925)
- Burrhus Frederic Skinner (operant conditioning; Skinner 1950).

It was not until mid-20th century that the potential for using behavioural methods to treat patients with psychological conditions was realised. Joseph Wolpe developed a technique called systematic desensitisation for the treatment of phobic anxiety (Wolpe, 1958). In this technique, the patient is taught deep muscle relaxation and a very detailed hierarchy of fears is produced. The patient is very gradually exposed to the fear while inducing relaxation. This treatment worked at reducing anxiety but was painstakingly slow and any therapeutic gains tended to be lost if the patient subsequently became anxious. Thus the treatment was rendered virtually obsolete in the 1970s with the development of graded *in vivo* exposure.

Real-life exposure methods were pioneered by James Watson and Isaac Marks (1971) in the treatment of phobic disorder. Following on from this, a range of conditions were added to those that could be treated using behavioural psychotherapy. These behavioural approaches remain the treatments of choice for most phobic anxiety, obsessive–compulsive disorders, skill-deficit disorders (e.g. social and sexual) and mild to moderate depression (behavioural activation). They are also a major component of the treatment of many conditions, including health anxiety and hypochondriasis, body dysmorphic disorder, eating disorders, addictive problems, and schizophrenia.

Second generation therapies

Simultaneously with the development of behavioural psychotherapy Albert Ellis, an American psychologist who had trained as a psychoanalyst, broke away from the psychoanalytic school and established the basis of rational emotive behavioural therapy (REBT; Ellis 1962). In REBT (also known as rational emotive therapy and rational therapy) the basic theory is that, in the main, people are not disturbed by negative events but by their beliefs about these events. These beliefs involve the world, themselves and others. The ABC model states that 'A' – the activating event (or adversity) contributes to 'C' – the behavioural and emotional consequences. However, the 'B' – beliefs about the activating event – moderates this response. The activating event can either be an external event or a thought about the past, present or future. In therapy, patients are asked to confront these beliefs with rational responses.

Aaron Temkin Beck was also trained as a psychoanalyst and worked as a psychiatrist in Pennsylvania. He started by experimentally investigating psychoanalytical concepts and through this developed his model for depression (Beck *et al*, 1979) and, subsequently, anxiety disorder (Beck *et al*, 1985) and personality disorder (Beck *et al*, 2003). It is this form of cognitive intervention which is the most widely used with patients and it is referred to in this book. Beck described the negative automatic thoughts (NATs) and how these could be challenged to alter mood. The approach is described in full in Chapters 8, 9 and 10.

Introduction to third generation (third wave) CBT

At the turn of the 20th century, many therapists and researchers began to question the shortcomings of CBT. There developed a group of loosely connected therapies which have been called 'third wave' or 'third generation' CBT therapies. These therapies have several things in common:

- all are empirically based and subjected to scientific evaluation
- all move to being more behavioural in orientation and less concerned with cognitions *per se*
- rather than examining the content of cognitions, these therapies concentrate on how the patient responds to these cognitions (i.e. looks at the direct behaviour resulting from these).

Therapies that are included under this heading are:

- mindfulness
- behavioural activation
- acceptance and commitment therapy (ACT)
- dialectical behaviour therapy (DBT)
- integrative couple therapy (ICT)
- other therapies (e.g. functional analytic psychotherapy).

To practise some of these therapies, such as DBT and the cognitive–behavioural analysis system of psychotherapy, requires therapists to attend a separate course as well as receive supervision.

The issue with many of these third generation CBT methods is currently the lack of empirical evidence of their efficacy in treating disorders. A recent Cochrane review of treatments for depression found two studies examining ACT and one examining behavioural activation which met the criteria for analysis. The final conclusion was that both treatments appeared as effective as CBT in acute depression (Hunot *et al*, 2013).

Current position regarding CBT

Over the past 50 years, behavioural psychotherapy treatments have been developed for a variety of conditions. These treatments are simple, effective and have a strong evidence base for a range of psychological conditions. Although they require the therapist to have the ability to form a good relationship with the patient and to be empathic and sensitive to the patient's emotions, they do not require a high level of specialised training beyond that. All that is needed is a core mental health professional experience, some background knowledge and clinical supervision to enable most people to conduct exposure therapies and devise skills acquisition and reinforcement regimes. Owing to this, the key advantages of behavioural psychotherapy are that it is effective (see list of conditions which can be treated earlier in this chapter), it is cheap (highly specialised therapists are not necessary) and it produces rapid results.

The development of CBT meant that the range of conditions which could be treated using a pragmatic evidence-based method widened and included, for example, generalised anxiety and panic, depression as well as health anxiety, body dysmorphic disorder and social anxiety. Very soon CBT was being hailed as a panacea that could solve a range of psychiatric conditions. Inevitably this meant it would not live up to all the extreme expectations. Some of the treatments are less evidence-based than others. Also there has been a tendency to 'throw out the baby with the bath water' as many therapists now only use CBT for conditions where an evidence-based treatment was established. For example, cognitive approaches were often applied in simple phobias and obsessive–compulsive disorder (OCD) where there is no evidence to suggest these are preferable to the simpler methods of exposure. As will be suggested in Chapter 7, it may be preferable to focus the cognitive approaches in these conditions on people who have specific problems in performing exposure methods.

Overall, CBT is:

- intellectually more attractive to therapists (and some patients) than behavioural psychotherapy
- more expensive than behavioural psychotherapy (therapists need more training and treatment tends to take longer)
- known to be effective in certain conditions such as depression, generalised anxiety, health anxiety and social anxiety
- being used for some conditions with little evidence base to demonstrate its efficacy, where caution is needed in claiming its superiority to other methods
- well established with a large number of CBT-trained therapists available across the high-income countries.

The third generation therapies have recognised some of the shortfalls of concentrating on cognitions and represent a move back to more strictly behavioural methods. Many of the treatments remain quite complex and involved, and yet there is considerable overlap between many of them. There is a need for detailed, good-quality research to examine not only their true effectiveness but also which components of the packages are the most valuable. In general, third generation therapies:

- represent a move back to more behavioural methods
- often are contained in complex packages (with the exception of behavioural activation)
- often require therapists to attend dedicated courses, training only in one particular therapy, making them expensive and, some being patented, exclusive; they are thus, in general, more expensive to deliver
- are not as well researched as the rest of CBT
- need to have the effective components of these complex packages isolated.

Human nature means that even if we have good, effective, reliable treatments available, we will tend to be attracted to the newer, more

exciting treatments that are developed and forget the advantages of some of the older methods. As will be shown throughout the book, often treatments change with fashion, whereas existing treatments may work as well or better than the ones which have replaced them. One example is in the use of long-term schema-focused CBT for personality disorder and DBT for personality disorder. There is research to suggest that these approaches are superior to waiting-list controls (Stoffers *et al*, 2012), but there is difficulty in claiming with confidence that they are preferable to more traditional psychodynamic psychotherapy or the more recently introduced psychoanalytically oriented day-patient mentalisation-based treatment. Given these provisos, it is difficult to know the value of the new treatments in the long term.

New developments and the future

New developments which have proven useful include computerised treatment packages. These computerised treatments were first introduced in the 1980s (e.g. Carr *et al*, 1988). They became more widespread with the greater availability of computers in the home as well as at specialist centres. The evidence base for this type of approach is growing in the area of anxiety disorders and depression (Andrews *et al*, 2010; Christensen *et al*, 2014). Increasing availability of mobile technology has led to the development of mobile phone and tablet applications which mean the patient can access therapy wherever they wish (Watts *et al*, 2013). There is huge potential for technology to deliver more therapy in more sophisticated ways in the future. However, there should be a note of caution as already there is a plethora of programmes purporting to treat common psychological conditions. These vary in their quality and the evidence behind their advice. Whereas some individuals with milder conditions may be able to access these programmes and complete them unaided to good effect, many more will also require some advice and guidance from trained professionals to assist them in the choice and application of the treatment. The use of such applications is thus often best thought of as a way of delivering therapy to more people but still requiring some trained interventions from a professional.

Another development in the UK was the launch in 2007 of the government initiative Improving Access to Psychological Therapies (IAPT). This scheme aimed to introduce into primary care widespread services providing CBT treatment to people with depression and anxiety disorders (Clark *et al*, 2009). This initiative has resulted in thousands more people receiving appropriate and effective treatment at an early stage. Treatment is delivered by specially trained graduate workers and supervised by trained psychologists. However, the sheer volume of patients accessing these services has led to a tendency for a 'one-size-fits-all' approach in some cases. Whereas overall excellent outcomes have

been obtained, some patients slip through the net. There are now fewer trained CBT therapists in secondary care services and most secondary care services specialise in the psychoses and bipolar disorders. Some more severely ill patients with anxiety and obsessive–compulsive disorders require more specialist interventions, which are frequently unavailable. We need to continue to monitor the outcome with the IAPT services and ensure that those with more complex conditions are signposted appropriately to experts in the field. For example, a recent meeting of OCD Action (a national UK charity supporting people with OCD) highlighted that some individuals with OCD are receiving generic anxiety management training rather than the graded exposure they require (J. Rose, 2014, personal communication).

The future is always difficult to predict and undoubtedly will involve 'forgetting' some of the old effective treatments as people try to invent newer, more 'fashionable' ways of treating patients. It is to be hoped, however, that with increasing reliance on treatment protocols and reviews of the literature, we can maintain the older reliable and effective treatments while fully scientifically investigating newer treatments and developing newer, more cost-efficient treatments for a wider number of patients.

Key learning points

- First wave behavioural treatments are still valid, useful, cost-efficient treatments for a variety of psychological disorders, including obsessive–compulsive disorders, phobic anxiety, social skills deficits and habit disorders.
- Second wave treatments include CBT for depression, generalised anxiety, social anxiety and health anxiety.
- Third wave treatments involve a mixed bag of treatments, generally with a move away from cognitive therapy and back to more behavioural methods. Many of these treatments also involve mindfulness.
- There is, so far, less robust evidence for third wave treatments than for behavioural or cognitive interventions.
- Third generation treatments include:
  - mindfulness, a form of meditation where the individual is encouraged to concentrate on the 'here and now'
  - behavioural activation
  - acceptance and commitment therapy
  - dialectical behaviour therapy
  - integrative couple therapy
  - other therapies (e.g. functional analytic psychotherapy and the cognitive–behavioural analysis system of psychotherapy)
- The development of IAPT services in the UK has vastly increased the number of patients with anxiety and depressive disorders who can receive treatment.
- Computerised CBT is now realistically available to most of the population and is developing rapidly.

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CHAPTER 2

Assessment

Overview

This chapter gives a full description of assessment of the patient for CBT and the development of the cognitive–behavioural formulation. The assessment starts with a full description of a thorough psychiatric history and looks at various *aides-memoires* and models of symptom development before demonstrating how a full cognitive–behavioural formulation can be derived. There is full description of the measurement of problems, the identification of goals and the roles of behavioural tests and questionnaire assessment.

Many people assume that there is a great mystery to the art of performing a good cognitive–behavioural assessment. In fact, this is far from the truth and any thorough clinician should elicit sufficient information to enable an adequate formulation to be made, and to implement a treatment regime. Following this procedure, measures of the problem are used to gauge the severity and to enable both the therapist and the patient to monitor progress, success or failure of the treatment.

To obtain a CBT assessment does, of course, require that the therapist is a skilled interviewer who is familiar with putting people at ease and dealing with patients. As the skills of psychiatric and general psychological interviewing are beyond the scope of this book, any reader who is unsure about this should not attempt CBT assessment until they have undergone a refresher course.

The chapter is divided into four main sections. The first concentrates on CBT history-taking and assessment, the second on the CBT formulation, the third on the education of the patient and planning treatment, and finally, the fourth section discusses the use of baseline and successive measures of the problem. As CBT psychotherapists come from a whole range of mental healthcare professions, it is important that these assessment procedures are used as an adjunct to rather than a replacement for general assessment procedures. All therapists should have a protocol in their mind for obtaining

general information and assessing psychiatric patients. Just because a patient arrives at a clinic referred for CBT does not exclude the possibility of other major mental health problems, or even serious physical disorder. For example, a patient was referred to me with 'agoraphobia', subsequently diagnosed as chronic fatigue due to chronic lymphatic leukaemia; another patient was referred with 'generalised anxiety and depersonalisation' but was found to have temporal lobe epilepsy; and many patients are referred with various anxiety syndromes whereas in fact they are severely depressed and need the depression treated first.

The first section of this chapter is aimed at a medical audience who will normally combine a diagnostic psychiatric interview with the initial CBT assessment. Non-medical readers may still find this helpful, though they may wish to concentrate on the subsection on checklists and mnemonics (pp. 10–13) and add this to the normal assessment procedures as appropriate to their mental health discipline.

From medical assessment to CBT assessment

In most specialties of medicine, the doctor takes a full history from the patient and then assesses the symptoms and signs to arrive at a diagnosis. If a patient was seen by a surgeon and said they had 'appendicitis', it is unlikely that the doctor would write this down as a diagnosis unquestioned. Unfortunately, this is not always the case in psychiatry. Patients may say they have 'panic attacks' or 'generalised anxiety' and the psychiatrist may not fully investigate the statement. They may obtain exhaustive details of the patient's family and early history but fail to gain precise descriptions of current symptomatology. With any symptom it is worth looking at ten main questions which make the unlikely mnemonic of 'Dad's car fad' (Box 2.1).

After obtaining details of the symptoms in this way, it is important then to trace the progress from their onset, with any variations in symptomatology and details of the circumstances and life events which may have occurred at various times throughout the history. This information is vital as it may radically alter the formulation and resultant treatment. For example, a 25-year-old woman presented with a 2-year history of fear of dirt and germs as she worried that she might catch a fatal disease. This fear was accompanied by avoidance of touching anything that had been touched by other people unless using tissues or rubber gloves and extensive hand-washing and cleaning rituals. Whereas at first this may have appeared to be a straightforward obsessive–compulsive history which would be best treated by graduated exposure to the feared situation in real life and self-imposed response prevention (see Chapter 7), it transpired that these started following a vicious rape attack. Treatment therefore needed to start by addressing her post-traumatic stress disorder (PTSD; see Chapter 15) before proceeding to treatment of the residual OCD.

Box 2.1 Ten questions instrumental in obtaining accurate psychiatric diagnosis – the 'Dad's car fad' mnemonic

Description. Full description of what the patient means by the symptom. What does it feel like? What happens?

Associated phenomena. Description of the thoughts, fears and emotions of the patient at the time of experiencing their symptoms.

Duration. Duration of all the symptoms.

Severity. Severity of all the symptoms.

Course. A chronological description of what happens from the very first symptom to resolution of the symptom.

Aggravating factors. Does anything make the symptoms worse or more likely to occur?

Relieving factors. Does anything make the symptoms better or less likely to occur?

Frequency and periodicity. How often do these symptoms occur and do they vary in severity?

Associated phenomena. Any other symptoms that have occurred? If the answer is affirmative, then repeat the same questions with each of these symptoms.

Diurnal variation. What time of day, when, where and with whom do the symptoms occur?

Once the full history of presenting complaints has been obtained in this way, the rest of the details of the patient's life history, family history, past medical and psychiatric problems and their treatments, drug history and social circumstances is obtained in the usual way. Whereas in a CBT assessment much less emphasis is placed on this information than on the presenting complaints, it is foolhardy to miss out these major areas. To exclude these enquiries could mean that important information which may alter the formulation and recommended treatment regime is missed.

The next stage is the mental state examination, which is followed by sharing the formulation with the patient, educating them about their problem and the suggested treatment before moving on to obtaining baseline measures and planning treatment in more detail with the patient.

Such an assessment may sound daunting at first sight, however, there are a number of mnemonics and checklists that can be used by the therapist to ensure all the vital information is obtained.

Checklists and mnemonics

When assessing a psychiatric symptom or problem behaviour, it is initially useful to think of two mnemonics, both remembered by the letters ABC: 'antecedents, behaviours and beliefs, and consequences'; 'affect, behaviour and cognition'.

Antecedents, behaviours and beliefs, and consequences

This mnemonic, coined by O'Leary & Wilson (1975), serves to remind the therapist that the antecedents and consequences of a behaviour, as well as the patient's beliefs about it, can modify the frequency of the behaviour. Clearly these factors should be examined and form part of the formulation as treatment will usually be geared towards modifying them.

For example, in the case of June, a patient with agoraphobia whose full history is given in Chapter 6 (Case example 6.1, pp. 77–80), the problem could be presented graphically (Fig 2.1).

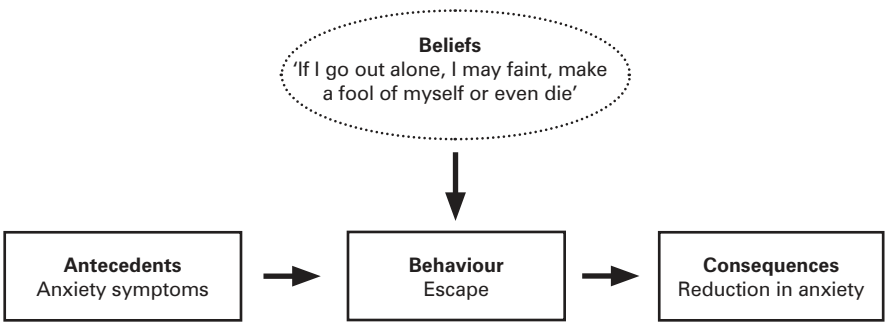

Fig 2.1 Relationship between antecedents, beliefs, behaviour and consequences (Case example 6.1).

Although similar analysis could be applied to all the case histories given in this book, the case of Flora (Case example 2.1, continued in Chapter 3, p. 32) also demonstrates the model (Fig. 2.2).

Case example 2.1: Incontinence treated with CBT

Flora, an 82-year-old woman, had a cerebrovascular accident 2 years earlier that had resulted in moderate intellectual impairment. She had spent the past 2 years living in a care home, where incontinence was a problem to the staff, who had to change her pad 8 or 9 times daily. This was not felt to be organic in origin, but attempts to regularly 'toilet' Flora had not produced any obvious success. Despite this, it was noted with interest that Flora was rarely incontinent overnight. The staff found her difficult because of her problem and requested she be moved to a more intensive nursing facility. Her GP referred her to the clinic for CBT.

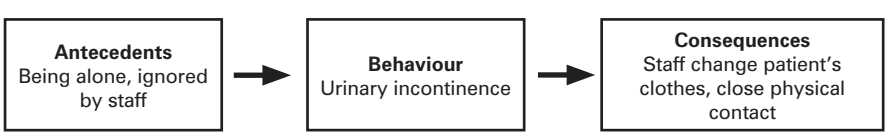

Fig. 2.2 Relationship between antecedents, behaviour and consequences (beliefs unknown); Case example 2.1.

Affect, behaviour and cognition

This mnemonic can not only be used to describe symptoms in a cognitive and behavioural formulation but also act as a useful model to describe how various treatments alter symptoms (Fig. 2.3).

This model demonstrates how affect, behaviour and cognition are all interdependent and how physical symptoms can alter all three. For example, if we move clockwise around the diagram, and start with affect, it is immediately obvious that how an individual feels affects the way that person thinks. Similarly, how someone thinks affects what they do and what someone does has an effect on how they feel. The same interrelationships can be seen by moving anticlockwise round the diagram. Physical symptoms can also affect an individual's thoughts, emotions and behaviour, and *vice versa*. Some drugs directly relate to physical symptoms, such as beta-blockers for anxiety, which may reduce symptoms without directly treating the problem.

If this model is applied to June (Case example 6.1), Fig 2.4 is obtained. From this example, it will be seen that the therapist decided to treat June purely by the behavioural technique of graduated exposure. This is because of the interdependent relationship of the various facets of psychiatric symptomatology. Altering June's behaviour was sufficient to alter her negative cognitions, disturbed affect and physical symptoms. This fact is important, as therapists can become prematurely seduced into cognitive therapy with a patient with catastrophic cognitions, instead of using the

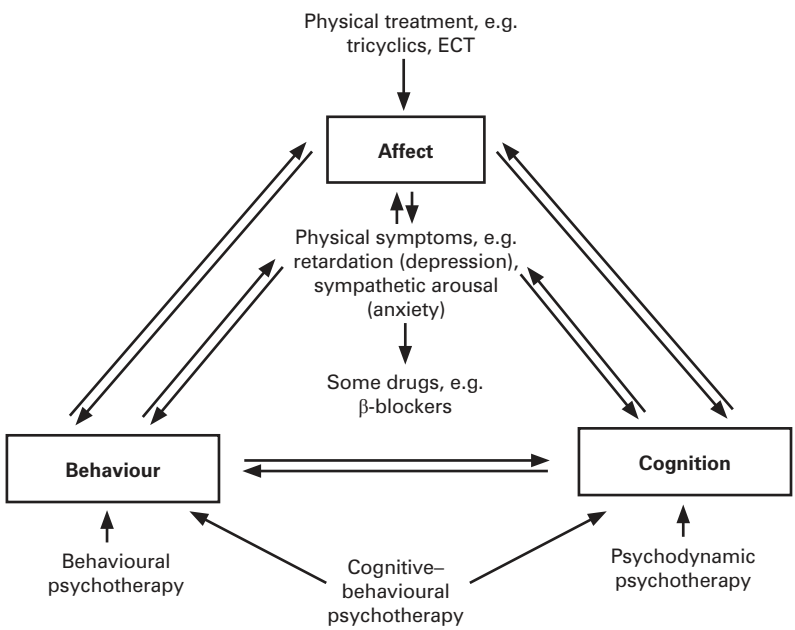

Fig 2.3 Relationship between different types of symptoms and therapeutic strategies.

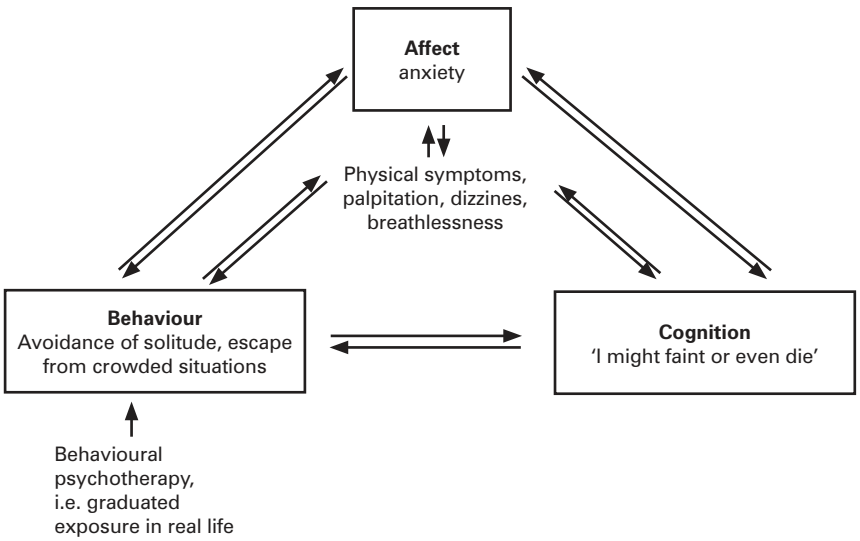

Fig. 2.4 Application of ABC model for June (Case example 6.1).

easier and less time-consuming behavioural methods, which are often the most powerful way of altering cognitions.

Predisposing, precipitating and perpetuating factors (the three Ps)

Assessment of these factors is a vital part of any CBT assessment and is fundamental in formulation and treatment planning. The case history of Lorraine and Michael (Case example 5.3, pp. 62–67) demonstrates some of these factors (Table 2.1).

In this example, it is clearly important for the therapist to be sensitive to and address many of the predisposing and precipitating factors as well as those which are perpetuating the problem.

Table 2.1 Factors affecting sexual dysfunction (Lorraine, Case example 5.3)[a]

Predisposing factors	Inadequate sexual information Parental attitude to sex School attitude to sex Belief that sex was 'dirty'
Precipitating factors	No clear precipitant as lifelong problem but perhaps parental disapproval when Lorraine moved in with Michael
Perpetuating factors	Guilt Continued parental disapproval Fear of pregnancy Michael's attitudes and beliefs

a. Lorraine had received very little sexual education at school or at home and found her first discussions about sex traumatic and unpleasant. She had been taught to consider sex as a sin and dirty. Michael had had early loss of confidence during sex as was told his penis was small.

Abbreviated assessment or screening

It is sometimes necessary to carry out an abbreviated form of assessment owing to lack of time. In these cases it is often useful to remember the plan of behavioural assessment described by Lazarus (1973) as necessary information to devise a behavioural programme. A brief CBT assessment can also be performed in this way, provided a full diagnostic and psychiatric assessment has been carried out.

Lazarus' scheme can be remembered by the mnemonic BASIC ID. This represents the major headings in history-taking: behaviour, affect, sensations, imagery, cognition, interpersonal relationships, drugs (Box 2.2 presents this schema based on Case example 8.3).

Box 2.2 BASIC ID history-taking

Behaviour Freda described how she felt she lacked energy and was thus less able to go out with friends. Although she had had a difficult few years initially caring for her elderly father and then her mother, she still had a large number of friends with whom she could socialise and had managed to ensure she had gone out at least once a week while caring for her parents. Since her mother had been admitted to a care home, Freda found she had withdrawn much more from her previous social life. She had increasingly stopped going out and instead concentrated wholly on her work and visiting her mother in the care home. At assessment, she said 'I think I've forgotten how to have fun!'.

Affect Her mood was low and flat. It was difficult for her to experience enjoyment any more. Even her favourite foods did not taste as good as they had in the past. While at work, Freda often felt agitated and dissatisfied with her performance. She was frequently anxious as she felt she was not performing to her full potential. Freda also admitted that she regularly felt guilty for not caring for her mother herself. Expressing her hopelessness, she said 'I feel I am a failure at everything…I am no good at work; I failed my father as I couldn't keep him alive; I've abandoned my mother to a care home and now I can't even be bothered to be a good wife to my husband or a good friend to anyone.'

Sensations Freda said she spent much of her time feeling extremely tired and exhausted. She had experienced a number of physical problems recently including more frequent headaches, muscle pains as well as general lethargy. If she did make an effort to engage in a pleasurable activity, she found she enjoyed it much less that she had done in the past. In her words, 'everything is flat and dull now'.

Imagery Freda admitted that she frequently had images of bad events befalling herself, for instance losing her job owing to her worsened performance. She also had frequent images of bad things happening, for example her mother falling out of bed in the care home and not getting the help she required, her children being involved in a catastrophic accident. These images made her anxious as well as deeply concerned about her own perceived lack of energy as she felt she 'should be able to cope and just get on with things'.

Cognition Freda had multiple beliefs concerning her perceived failure and inadequacy as a daughter, a wife, a mother, a work colleague; and a friend. She felt she was a total failure in everything. At times she had felt it would be better if she died but she had no intention to harm herself as she realised this would greatly upset her family and friends. Freda also had high standards to which she felt she should always aspire. Extremely critical of herself, she found it hard to take any credit for her previous successes in life.

Interpersonal relationships Although very close to her mother, Freda tearfully admitted that she had not always had such a close relationship with her father. She found him overbearing and had frequently rebelled against him when she was younger. This thought did worry her and she wondered if she had partially caused the stress leading to his demise. She married her husband at the age of 25 and he had been her first and only sexual partner. She described him as a 'good man, a good father and a caring husband'. Often she worried that he would become bored with her and her depression and leave her. Although he was caring, supportive and would help her whenever he could, he was 'not a man who would handle emotion' and so she had been unable to confide all her worries in him. Whereas she had been close to both her daughter and son when they were growing up, they had moved to different parts of the UK due to their jobs. Her daughter telephoned her regularly every week but her son was more sporadic about when he called. Freda worried that her son did not call owing to her failure as a mother, despite being reassured by her friends that this was unlikely to be the case and that he was just busy with his own life. She had good close friends whom she had known since school days. Before her depression, she would go out with friends once a week and she would also go out for a meal or to the theatre or cinema with her husband every 2–3 weeks.

Drugs Freda was a social drinker who, prior to her mother going into a home, would go out with friends once a week and drink a glass or two of wine (175 ml) on each occasion. She did not drink alone but only in social situations. Thus she had not drunk anything for the previous 4 months as her husband never drank at home with her. She did not smoke and had never used any illicit drugs. Her GP had prescribed sertraline 50 mg a day for her but she had refused to take this as she felt taking drugs was 'a sign of weakness'. She also was on calcium and vitamin D_3 supplement but no other medications.

Cognitive–behavioural formulation

Examples of cognitive–behavioural formulations will be given throughout this book. However, it is worthwhile asking what a cognitive–behavioural formulation is and how it differs from any other type of formulation. Generally, it could be said that it is a hypothesis about a disorder, behaviour or symptom which attempts to identify any possible predisposing, precipitating and perpetuating factors or mechanisms. A formulation may be presented in a few sentences or as a diagram. It is not carved in tablets of stone and thus the formulation may alter as treatment progresses and other factors come to light. Usually it is helpful to share the formulation with the

patient. It is often beneficial for them to see that their problem, which may have previously seemed insurmountable, can be summarised in a few short sentences and become more manageable. Discussing the formulation with the patient also presents an opportunity for the therapist to ensure that they have understood the problem fully, as well as helping patients to feel that the therapist has taken note of them. An example of a CBT formulation is given in Box 2.3 (based on Case example 6.3, pp. 82–84) and presented in a diagram (Fig. 2.5).

Box 2.3 A CBT formulation

'Gwen, although you do not describe any problems with hospital and dental procedures before the age of 14, the history of your mother and maternal aunt having similar problems suggests that there may well be some genetic predisposing factors, as well as the fact that you may have learned that these procedures might be accompanied by anxiety and fainting.

After your routine medical examination, you experienced minor symptoms of light-headedness and nausea when told you would need to have a blood sample taken. The fact that the doctor was unsympathetic and the nurse held on to you tightly and roughly would have increased your unpleasant sensations as well as being aversive in their own right. After the procedure, you fainted. You therefore learned to associate visiting doctors with feeling ill and frequently fainting.

Because of your unpleasant experiences, you started to reduce the number of visits to the doctor and dentist. Also, you told me that on several occasions you had walked out of a doctor's or dentist's surgery because you had catastrophic thoughts that you were going to be ill. These thoughts led to you having symptoms of feeling nauseous and unwell. Avoiding those visits and walking out of the doctor's is likely to make your fear of the situation worse. High anxiety is horrible and therefore a reduction in anxiety is like a reward. In your case, escaping from the situation or avoiding the situation reduced your anxiety. These behaviours were then 'rewarded' by a reduction in anxiety. If you reward any behaviour, you increase the chances of it recurring. Therefore, every time you escaped from or avoided contact with doctors and dentists, you served to increase your fear and strengthen your belief that avoidance and escape were the only way to avoid unpleasant sensations. You, therefore, became increasingly phobic of these situations until the present time'.

Education and planning treatment

Cognitive–behavioural therapy differs from most other types of psychiatric treatment, as the aim is nearly always to train the patient to become their own therapist. The advantages of this approach are in the cost-efficiency of therapist time, as well as enabling the patient to monitor and implement appropriate action if there are any early signs of relapse. However, this type of approach does mean that more time needs to be spent in the early stages of treatment, in explaining the exact reasons for any suggested remedy.

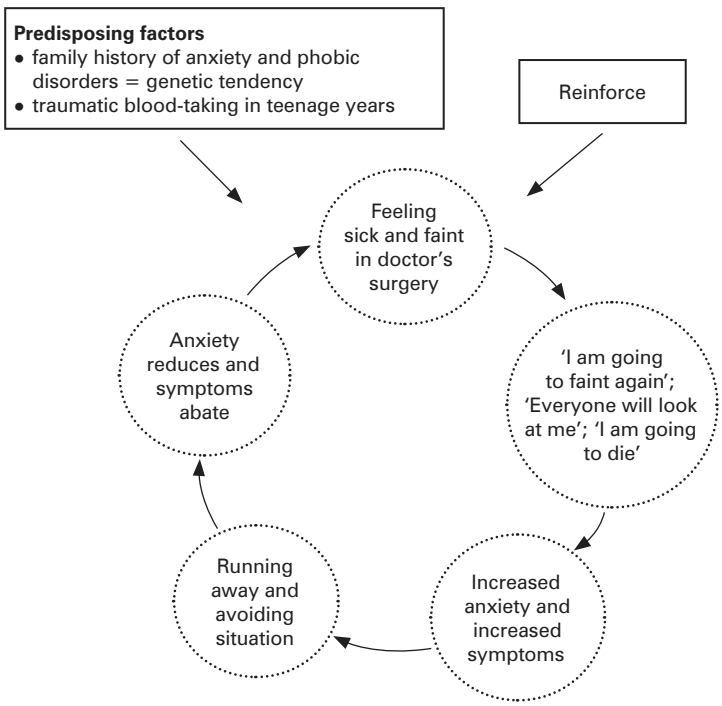

Fig. 2.5 Diagram of formulation for severe blood and injury phobia.

The case histories described in this book will also demonstrate that a high level of motivation and adherence to therapy is needed, as the patient is often asked to do things that are frightening or aversive to them. Adherence can often be dramatically improved by the therapist ensuring that the information given to the patient is honest, accurate and not overly optimistic or pessimistic. Treatment is usually designed by the patient and therapist together, and not in a (traditionally) prescriptive manner. The term 'collaborative empiricism' has been used to describe the way in which patient and therapist work together to find an answer to the patient's problems (Beck *et al*, 1979).

Examples of patient education and treatment planning will be seen throughout the book. An example is given here in Box 2.4, again based on the story of Gwen (Case example 6.3, pp. 82–84).

Once the therapist had answered the patient's questions about anxiety and treatment, the next stage is to establish the overall targets which the patient wishes to achieve by treatment and then work out a hierarchy of situations of varying difficulty. To judge the difficulty of each situation, the therapist may ask the patient to rate their anxiety on a 9-point scale (Fig. 2.6), which will be used frequently throughout this book and is described fully by Marks (1986).

Box 2.4 Patient education and treatment planning

'The first thing I want to explain to you is about anxiety. Anxiety is an extremely unpleasant experience but it is important to remember that it does no harm to you. People do not die or go mad from anxiety. Second, anxiety does reduce if you remain in situations for long enough.

In your case, when in a fear-provoking situation such as visiting a doctor, you initially experience typical symptoms of anxiety such as a pounding heart and feeling shaky. If possible you will try to escape at this time. However, as I have already explained to you, although escaping seems a good idea at the time as it reduces your anxiety, you are teaching yourself that the only way to deal with the situation is to escape from it or to avoid it completely and therefore, each time you escape from a situation, you make the problem worse.

If you do not manage to escape from the situation, another physical mechanism comes into operation and you feel nauseous, dizzy and frequently faint. This is also a part of the anxiety reaction. In the majority of fear-provoking situations, we react with what is known as the 'fight or flight' reaction, which we recognise by a rapid heartbeat and increased rate of breathing. This reaction is inbuilt and instinctive and prepares our bodies for the physical exertion of either running away or fighting the threat. However, in situations where injury is inevitable many animals, including ourselves, have an inbuilt reaction which in many ways is opposite to the fight or flight reaction. In this case, the heart slows down, breathing becomes shallow and nausea and vomiting may occur. This reduction in blood flow means that, if injury occurs, you are less likely to bleed to death than if your heart was pumping away at full rate. This is all very well in the wild, but your body is oversensitive to non-life-threatening situations such as a visit to a doctor or dentist.

The way to help is by asking yourself to gradually face up to the things that you fear, and to remain there long enough until your anxiety symptoms subside. This often takes between 1 and 2 hours. We will now work out together a series of situations which are increasingly difficult, and which you will need to master for treatment.

For the early exposure sessions at each stage of difficulty, we may have to start with you lying flat to reduce the risk of fainting. Your anxiety will reduce as you practise each stage, and we will move you gradually into a more upright position.

I should also emphasise that, although the treatment sounds difficult, the majority of patients who have this treatment improve. Do you have any questions about anything I have said?'

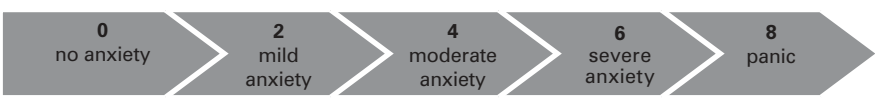

Fig 2.6 Nine-point scale for anxiety.

It is important not to swamp the patient with too much information and to ensure that it has been understood. Information and vocabulary need to be tailored to the educational and intellectual level appropriate for each patient. In addition, the patient's social circumstances and preferences must be taken into consideration. This does not mean that treatments without an evidence base should be offered based on patient preference but that all options that have been shown to be useful should be discussed along with the advantages and disadvantages of each. It is then acceptable to present the treatment package the therapist feels will be the most useful. Patients may wish to debate this care plan and the overall package may need modification as a result.

Finally, patients often forget what has been discussed in the clinic and it is useful to provide them with some form of written information to be taken away. This may be in the form of information sheets or by recommending a particular self-help book. (At the end of most chapters I have listed workbooks for therapists and appropriate self-help texts that can be suggested to patients to read.) Please always remember to first read any book you recommend to ensure it is in keeping with your advice. Also remember that some patients may not wish to read a whole book and so shorter texts and individualised material may be more appropriate.

However, it is also important to give some tailor-made written material of what was discussed in the session and how the patient's problem is viewed. It is often useful to jot down the main points of the formulation on a piece of paper and give this along with the diagram of how the problem is maintained. This can be written during the interview with the patient and initially used to illustrate the information given about anxiety (Box 2.5; full patient history is given in Case example 8.3, pp. 121–124).

Box 2.5 Information given to patient about anxiety

In the example of Freda, a 50-year-old office supervisor treated for depression by cognitive therapy whose case history is described in Chapter 8, the following was said:

'I understand how very low you have been feeling and you have explained fully to me how recent events have contributed to these feelings. However, it is often the case that it is not events themselves that lead us to feel low but some thoughts that rush into our mind and make us feel miserable.

If I can demonstrate this, I want you to imagine that on my next appointment with you, you did not arrive and did not telephone to cancel. Now, imagine that I am prone to get depressed, my thoughts might be something like this: "She's not arrived, she must think I am a hopeless therapist. Everyone will soon learn about this and realise how useless a therapist I am. I must be a complete failure, no one could possibly love me. It is pointless continuing to live like this." Now what do you think I would feel like after having thoughts like that?'

Freda replied with a laugh, 'Very low and desperate, but that really is not logical because if I had not arrived I might have forgotten the appointment, or written it down wrongly in my diary, or been caught in traffic, or many other things. Also just because one patient missed an appointment does not mean you are a hopeless therapist, and even if you did believe you were a hopeless therapist, it would not mean you were a total failure and no one could love you.'

The therapist answered, 'That is right, it does sound silly when stated in this way, but I think we will discover that it is no more irrational than many of the thoughts which run through all of our minds from time to time, and are now contributing to you feeling depressed. These thoughts are called negative automatic thoughts, and to illustrate what I mean I would like you to describe to me the last time you had a bout of feeling really low and what was happening at that time.'

Freda then described an incident in which she had been having a cup of coffee with a friend. The friend had casually mentioned that her daughter had passed a piano examination recently. Freda found that she felt miserable. The therapist asked her to imagine herself back in that situation, and to repeat out loud the thoughts which went through her mind at that time. The following sequence was obtained:

'My daughter did not have the chance to learn the piano. I must be such a hopeless mother that I did not encourage her sufficiently. This pattern will continue throughout her life and she will be a failure. Once she is unemployed she will blame and hate me. I am no good as a mother, she would be better off living without me.'

The therapist then encouraged Freda to examine the evidence which supported and refuted the first of these thoughts: her daughter not learning the piano meant that she was a hopeless mother, who did not encourage her sufficiently. A more rational response was produced, namely that her daughter had showed no interest in learning a musical instrument and that she had been more interested in gymnastics, which she kept up until leaving for university.

Following this, the therapist explained the major thinking errors which people commonly make. These thinking errors are listed fully in Freda's case history in Chapter 8 (p. 121). Examples from Freda's own history were used to illustrate these where possible or the therapist gave another example. These thinking errors were then written down for Freda to read at home. She was also asked to fill in a diary over the next week:

1 Write down each negative thought you have and record the time and place when you had the thought. Put this in the left-hand column on a sheet of paper.
2 In the right-hand column on the sheet of paper, put down any evidence you can think of to contradict the negative thought. If you cannot think of any contradictory evidence at this stage, just leave the right-hand column blank.'

Later in Chapter 8 the reader will find a description of how this diary recording develops into the 'two-column technique', which is integral to cognitive therapy of depression.

Thes two examples (Boxes 2.4 & 2.5) should give the reader an idea of the level of information needed to gain a patient's cooperation with treatment. It is often useful to perform at least some basic measures of the problem at the same time, as these may help the patient to focus on areas of difficulty when planning treatment with the therapist.