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The Cognitive-Behavioural Paradigm

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The theoretical origins of cognitive-behaviour therapy can be traced back to the Stoic philosopher Epictetus, who in the first century AD observed that 'People are disturbed not so much by events as by the views which they take of them'. The implication of this observation is that situations (like objects in the visual world), are better viewed from some angles than from others and that, at least in principle, people choose their orientation. However a person's 'orientation' is itself influenced by his beliefs about himself in relation to the world. Thus if I believe myself to be a football referee I will watch the football match from a different 'angle' from that used if I believe myself to be a football spectator. The task of cognitive-behaviour therapy is to relieve emotional disturbance by helping people change their maladaptive beliefs and behaviours.

Underlying Theory of Personality and Motivation

From a cognitive-behavioural perspective human experience is viewed as a product of four interacting elements – physiology, cognition, behaviour and emotion (Figure 7.1). Thus if I am tense (physiology) when I come to write an essay this may lead me to think 'I am not going to write a good essay' (cognition), which in turn might lead me to feel anxious (emotion) and that might lead me to put my pen down and go for a walk (behaviour). The effect of going for a walk might be to reduce my tension (back to physiology), I may then be more inclined to think 'in reality I actually do quite well on essays' (cognition) and this may make me feel in turn more relaxed (emotion). In this instance a behaviour (going for a walk) has broken down the negative chain reaction. This behaviour itself may have been energized by my general knowledge (cognition) that going for walks lifts my mood. Within the cognitive-behavioural tradition, the primary emphasis is on breaking out of negative chains via the cognitive and behavioural ports of entry. It should be noted, however, that it is perfectly possible in principle to break negative cycles via the physiological port, for example a relaxation exercise involving tensing and relaxing each muscle group in turn, or via the

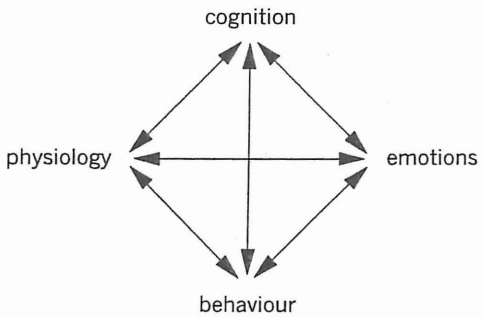

Figure 7.1 *The cognitive-behavioural model*

emotional port, for example playing a favourite music tape. Whilst the cognitive-behavioural approach to anxiety and depression and other emotional disorders has concentrated on changing cognitions and behaviours there has been a shift to include emotions as a port of entry when it comes to the treatment of personality disorders. To return to our example, if I thought that 'I am not going to write a good essay' but also that 'I am a stupid person and worthless', such a belief might sabotage all my efforts. Thus, I may not even go for a walk in the first place. This distinction between thoughts and beliefs becomes more apparent if we use Persons' (1989) method of conceptualizing clients' difficulties. She has a two-level model. The first level is one of overt difficulties, with cognitions, emotions and behaviour reciprocally interacting (Figure 7.2). The second level is one of covert difficulties, and it is at this level that core beliefs operate, for example, 'I am stupid'. Core beliefs are the tacit beliefs people have about themselves and their relationship to the world. The core beliefs are rarely verbalized and usually operate at the edge of a person's awareness. They are inferred beliefs from a person's responses to a wide range of situations. The core beliefs are moulded in childhood.

There are reciprocal interactions between levels one and two. My belief that 'I am stupid' may make it more likely that I will automatically think 'I am going to make a mess of something' when confronted with a task. But if I can change such automatic thinking (what are called automatic thoughts) across a range of similar situations then I may eventually change the core beliefs. With disorders such as anxiety and depression, that is the Axis 1 disorders in the *Diagnostic and Statistical Manual* 4th Edition (DSM IV; APA, 1994), automatic thoughts tend to be the target whereas with Axis 2 disorders in DSM IV, the personality disorders, the core beliefs are the more direct focus. Individuals differ in their core beliefs and it is the omnipresence of an individual's core beliefs

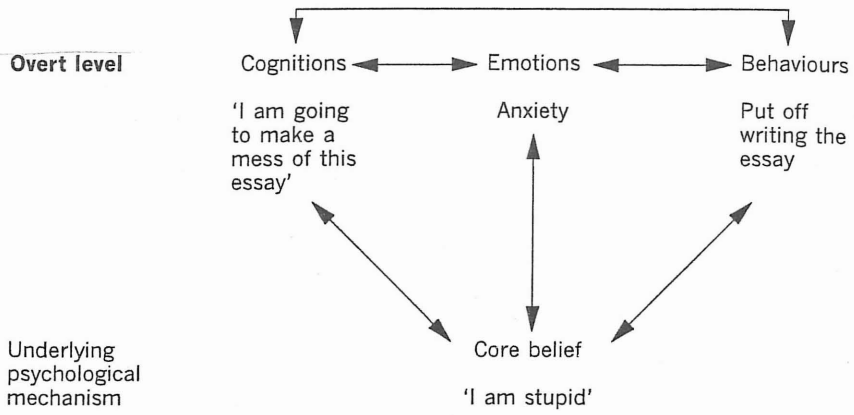

Figure 7.2 *Person's (1989) model of client difficulties*

that makes his or her behaviour relatively predictable and confers on that individual a particular personality. Beck et al. (1983), for example, have made the distinction between autonomous and sociotropic personalities. The autonomous personality bases his sense of self-identity on his achievements and would have a core belief of the form 'if I am not the top then I am a flop'. The sociotropic personality on the other hand believes that he needs the approval of others. His core belief is of the form 'I am nothing if I do not always have other people's approval'.

Within a cognitive-behavioural paradigm the motivation of an individual is held to be a product of two sets of beliefs – self-efficacy and outcome expectancies (Bandura, 1982). Self-efficacy relates to a person's belief in their ability to perform an action, whilst outcome expectancies relate to their belief in whether the outcome is worthwhile.

The assessment process

Cognitive-behavioural approaches have been developed differently for various disorders. It is therefore important to be able to identify and distinguish the different disorders. To diagnose patients use is made not only of a clinical interview but also of self-report measures. For example, the primary theme that emerges when interviewing depressed clients is one of loss, of life having lost its flavour, whereas the main theme permeating an interview with an anxious client is one of threat. A self-report measure such as the Hospital Anxiety and Depression (HAD) Scale (Zigmond and Snaith, 1983) is useful to distinguish the two conditions;

Anxiety	Depression
Feeling tense or wound up	Not enjoying things the way you used to
Getting a sort of frightened feeling as if something awful is about to happen	Being unable to laugh and see the funny side of things
Having worrying thoughts going through your mind	Not feeling cheerful
Inability to sit at ease and relax	Feeling as if you are slowed down
Getting a sort of frightened feeling like butterflies in the stomach	Losing interest in your appearance
Feeling restless as if you have to be on the move	Not looking forward with enjoyment to things
Getting sudden feelings of panic	Being unable to enjoy a good book or radio or television programme

Figure 7.3 *Indicators of anxiety and depression from Zigmond and Snaith's (1983) HAD Scale*

clients are asked to report the severity of each of the symptoms in Figure 7.3 on a scale of 0 to 3, and a score of greater than 8 on either sub-scale has been found to most reliably distinguish clinical cases of a disorder from non-cases.

A client's response to a question on the HAD can be an important discussion point in the assessment process. For example, a response of 'quite often' to the question on the frequency of panics should lead to further questioning as to whether the client actually experiences discrete panic attacks (usually 5–10 minutes' duration), so that a diagnosis of panic disorder would be warranted rather than for example generalized anxiety disorder. Different CB treatments have been elaborated for panic disorder (Clark, 1989), generalized anxiety disorder (Butler et al., 1987) and depression (Beck et al., 1979). Nevertheless there is some overlap in the treatment because of co-morbidity, the fact that many depressed clients are also highly anxious and that many panic disorder clients are often at least mildly depressed. The counselling approach used has to take account of any co-morbidity whilst at the same time having a primary focus on that disorder which is most debilitating for the individual. A differential diagnosis indicates the major and minor targets in the client's condition. Having specific criteria for different conditions provides a basis for answering the fundamental research question of 'which treatment works best for which client' (Paul, 1967).

Within the cognitive-behavioural paradigm it is suggested that each of the emotional disorders has a particular cognitive content, which can be assessed with self-report measures with varying degrees of established reliability. For example, for depression, the Dysfunctional Attitude Scale

(Weissman, 1979) is an often used and well-validated instrument; respondents are asked to register their agreement on a 7-point Likert Scale to statements such as 'My happiness depends more on other people than it does on me' and 'I can reach important goals without slave driving myself'. The cognitive content of a client's panic disorder can be made explicit using Greenberg's (1989) questionnaire, which contains items such as 'a panic attack can give me a heart attack' and 'I have to escape the situation when I start having symptoms or something terrible could happen'.

A cognitive-behavioural assessment requires not only an identification of cognitive content but also of the typical distorted cognitive processes of the client. Burns (1980) has listed what seem to be the ten most common self-defeating thought processes.

1 **All or nothing thinking** – seeing everything as black and white, e.g. 'if I am not in complete control, I will lose all control'.
2 **Over-generalization** – where it is concluded from one negative event that other negative events are thereby likely, e.g. 'I wasn't successful at that and now everything is probably going to fall apart'.
3 **Mental filter** – seizing on a negative fragment of a situation and dwelling on it, omitting consideration of any positive feature, e.g. 'town was crowded, it was awful, . . . oh yes I did get some great bargains and bump into some old friends . . . but it was so bad in town'.
4 **Automatic discounting** – a sensitivity to absorbing negative information and summarily discounting positive information, e.g. 'yes I was complimented, but he is nice to everyone'.
5 **Jumping to conclusions** – where a conclusion is inferred from irrelevant evidence, e.g. 'everyone stared at me because my stomach was bloated'. This often involves 'mind reading'.
6 **Magnification and minimization** – magnifying imperfections and minimizing positive attributes.
7 **Emotional reasoning** – using feeling as evidence of the truth of a situation, e.g. 'I feel guilty therefore I must have done something bad'.
8 **Should statements** – an overdose of moral imperatives, 'shoulds', 'musts', 'have to's' and 'oughts'.
9 **Labelling and mislabelling** – emotional reactions are in large measure a product of the label a person attaches to a phenomenon. An inappropriate label can produce a distressing reaction.
10 **Personalization** – egocentric interpretation of interpersonal events relating to the self, e.g. 'two people laughed and whispered something to each other when I walked by, they were probably saying I look odd'.

Paranoid personality
I am disliked by others
Life is a competitive struggle against external enemies
Therefore, I will excuse myself from blame and failure by attributing blame to others

Schizoid personality
I am a misfit
Life is a difficult place and human relationships are troublesome
Therefore, it is better for me to keep my distance and maintain a low profile

Anti-social personality
I am entitled to what I want
Life is a jungle where dog eats dog
Therefore, I will eat before I am eaten and defy their efforts to tame me

Obsessive-compulsive personality
I am liable to be held responsible for what goes wrong
Life is unpredictable
Therefore, I have to be on guard against anything that might go wrong

Figure 7.4 *Core rubrics for personality disorders*

These distorted cognitive processes can be found across the full range of emotional disorders and any one client will probably be particularly prone to a few of these processes. There is some overlap between the processes, it is not suggested that each self-defeating thought pattern is in a water-tight container.

In recent years the attention of cognitive-behaviourists has shifted to a focus on personality disorders, partly because these disorders may co-exist with an emotional disorder such as depression or anxiety and make it more difficult to treat the latter. Forgus and Shulman (1979) have provided a framework for examining the cognitive content of the personality disorders by asking clients to perform the sentence completion exercise below.

1 I am . . .
2 Life is . . .
3 So I . . .

Whilst each individual's response will be unique to them, it is argued that there are families of responses that typify the personality disorders. Completion of the above sentences by a client would give a brief summary (rubric) of that client in relation to others and the strategies he or she uses. Certain rubrics are held to be prototypical of particular personality disorders; these are called core rubrics (Figure 7.4).

To meet the diagnostic criteria for a personality disorder the client would not only have to manifest the criteria at the time of assessment but would also have to have exhibited such traits by early adulthood. It follows that the personality disorderd client will have exhibited the same view of themselves (I am), view of the world (Life is) and strategies

(Therefore), in early adulthood. Within the cognitive-behavioural framework the genesis of personality disorders is held to lie in the acquisition of maladaptive beliefs in childhood. These beliefs were probably functional in the context in which they originated but are maladaptive in the current adult situation. To trace the aetiology of personality disorder it is also useful to ask clients to complete the framework as if they were in childhood. Where the truthfulness of a client might be in question (for example, a client with a suspected anti-social personality disorder), evidence would need to be collected from significant others and 'slotted' into the framework. In moving from the treatment of emotional disorders to personality disorders there is a shift to a more historical focus with a greater emphasis on childhood material. Beck, Freeman and Associates (1990) have developed a similar framework to Forgus and Shulman (1979) using the headings View of self, View of others (a greater emphasis than in Forgus and Shulman on the interpersonal), Strategies and Main Beliefs, and have applied it to elaborate each of the personality disorders except for borderline personality disorder (BPD). Beck, Freeman and Associates were unable to explicate the specific thought content of BPDs and suggest that it is more their thought processes such as all or nothing thinking that are the primary problem. In addition they suggest their compulsiveness and low frustration tolerance complicate matters. Beck, Freeman and Associates also suggest that their chronically low self-esteem has to be a prime therapeutic target.

Young (1990) contends that dysfunctional experiences with early socializing agents and peers can lead to the formation of Early Maladaptive Schemas (EMS). He defines EMS as 'extremely stable and enduring themes (regarding oneself and one's relationship with others) that develop during childhood and are elaborated throughout an individual's lifetime. These schemas serve as templates for the processing of later experiences' (1990: 9). They are most in evidence when the person shows high levels of affect and overreacts to situations. He identifies 16 maladaptive schemas grouped under five headings.

1 **Impaired autonomy** – expectations about oneself and the environment that interfere with one's perceived ability to separate, survive and function independently.
2 **Disconnection** – expectation that one's need for nurturing, stable, trustworthy and empathetic relationships – social or intimate – will not be met in a predictable manner.
3 **Undesirability** – the expectation that one will not be desirable to other people in terms of any of the following: physical attractiveness, social skills, inner worth, moral integrity, interesting personality, career accomplishment, etc.

4 **Restricted self-expression** – inordinate restriction or suppression of one's emotions, impulses, natural inclinations or daily preferences in order to gain the respect of others or avoid guilt.
5 **Insufficient limits** – excessive personal wants that lead to difficulty meeting others' expectations or one's personal goals.

Young educates clients on how they use schema maintenance strategies (for example, look for information that supports their schema and discount information that contradicts the maladaptive schema). He also introduces the notion of schema avoidance, where the client will not think about certain material because it is highly affect-laden; this seems consistent with defensive notions such as denial. The third process he highlights is schema compensation: engaging in behaviour to compensate for an activated maladaptive schema (for example, a person who proves to himself and others how strong he is to compensate for an activated 'weakness' schema). The focus of therapy is schema change. This is done by the counsellor identifying and labelling the client's schemas and challenging them. Extensive use is made of imagery to evoke memories and feelings.

What does change mean and how is it brought about?

Change within the cognitive-behavioural paradigm is often synonymous with symptom reduction and behaviour change. Thus success with an anxious client would be gauged by say a reduction in the number of and intensity of the symptoms on the anxiety sub-scale of the Hospital Anxiety and Depression Scale described earlier. If the anxious client had also shown agoraphobic avoidance his/her improvement would also be assessed by his/her ability to venture forth alone. However, for some conditions such as depression, lasting symptom reduction, that is to say relapse prevention, is postulated to depend on the modification of core beliefs. Counselling psychologists are likely to consult not only with clients who might merit a diagnostic label on DSM IV but also with clients with problems in living; for both categories attention has been paid to the question of what constitutes clinical change. (This is an important question not only from the point of view of whether what the counselling psychologist does makes any 'real' difference to the client's life but also from the point of view of the audits demanded of employers of counselling psychologists. Jacobson and Truax (1991) have suggested three ways to operationalize clinically significant change:

1 When the post-test mean score of a client falls beyond the mean of a comparative dysfunctional group by two or more standard deviations.
2 When the post-test mean score of a client falls within two standard deviations of a normative group's mean.

3 When the post-test mean score of a client is more likely to have been drawn from the normative rather than the dysfunctional group's distribution.

For depression, norms for normal and dysfunctional groups are readily available (Nietzel et al., 1987), making the determination of clinically significant change easier than for other disorders where comparative data have yet to be assembled. Cognitive-behaviour therapy is not a single therapy and it may be that some cognitive-behaviour therapies turn out to be better than others at bringing about change with some disorders. They can be categorized under four main headings: coping skills, problem-solving, cognitive restructuring and structural cognitive therapy. First the similarities of the cognitive-behaviour therapies are described and then the differences. The family members share the following characteristics.

1 Therapy begins with an elaborate, well-planned rationale. This provides clients with an explanation of their disturbance and of the steps that they will be guided through to help them overcome their difficulties. In practice this means explaining that it is the interpretation and evaluation of an event (B) that is the major influence on emotional response (C), rather than the event/stimulus (A) *per se*. Analogies are useful to convey this message. For example 'the mind is like a camera, it depends on the settings and the lenses you choose as to what sort of photographs of events you take. It is possible to teach people to choose the settings and lenses so that you get a more realistic picture of the situation than the ones that you are typically disturbed about.'

The rationale for the behavioural dimension of therapy is usually explained in terms of activity as a prerequisite for a sense of mastery or pleasure. It is therefore necessary to overcome the inertia that emotional distress can produce.

The cognitive and behavioural dimensions overlap considerably. For example, a client may refuse to go to the theatre, something he once used to enjoy; that is, he resists the behavioural task on the cognitive grounds that 'I know I am not going to enjoy it, so why bother?' This roadblock would be tackled cognitively by suggesting that the thought he would not enjoy the play was a hypothesis; he does not have a crystal ball and as such he needs to conduct an experiment to assess the veracity of his prediction. At the start of therapy it is also important to outline the time scale of therapy, the likelihood of success and the importance of homework assignments.

2 Therapy provides training in skills that the client can utilize to increase his effectiveness in handling his daily life.

Clients are asked to record events between sessions that they experience as upsetting. These may be external events such as being criticized

by a spouse or internal events, for example a sudden change of mood looking out of the window watching the traffic go by. Having identified the triggering events and the emotional responses to these events, clients are asked to record what they might have said to themselves to get so upset, that is, to find the Bs of the ABC model. Clients may have greater or less access to the B depending on whether it is at the forefront of their mind or at the edge of awareness. Part of the counselling psychologist's therapeutic skills lies in making the Bs explicit and then helping the client challenge whether or not they are valid and useful and by whose authority they are held. For example, a client who experiences a down-turn in mood watching the traffic go by may have been saying to himself: 'Life is just passing me by, I'm always getting myself into a bad mood, I'll always be this way, I'm a failure.' A more rational response might have been, 'I am only 40, life begins at 40, some things I have done well, some badly. Join the human race.'

3 Therapy emphasizes the client making independent use of cognitive-behavioural skills outside of the therapy context.

If in the therapy session the therapist had, for example, drawn a client's attention to a constant theme of failure in his Bs, the client would be alerted that such thoughts could well be triggers for a lowering of mood outside the therapy session. Consequently the client would be given a mood monitoring exercise to conduct outside of therapy. First the client might be instructed to pause when she noticed the first signs of emotional distress. Then she would have to review her self-defeating talk for themes of failure. Having identified which theme or themes were operative, she would then apply the alternative rational response which had been selected and practised in therapy in order to behave in a way that could enhance her sense of mastery or pleasure.

4 Therapy encourages the client to attribute his improvement in mood more to his own increased skilfulness than to the therapist's endeavours.

If the client sees his improvement in mood as a product of his own change in thinking habits and behaviour and can continue using these skills, the therapist will be able to terminate therapy. Clients can be prepared to make such attributions by the therapist's constant emphasis on the importance of homework assignments. Essentially clients are being taught a skill for their independent use, and the more they practise it the more skilful they will become.

The cognitive-behaviour therapies can be categorized under four main headings, although there is some overlap between them.

Coping skills A coping skill has two components: a self-verbalization or instruction and a resultant behaviour. A client's difficulty in managing

particular situations may be due to a deficiency in a coping skill. For example, a depressed client's inability to be assertive, may be due to a belief that they should never express their own needs, and a consequent 'mumbling' at a time that they should express their needs. The Stress Inoculation Training (SIT) of Meichenbaum (1985) addresses both the cognitive and behavioural aspects of coping skills and is the most well-known therapy in this category. SIT is aimed at the reduction and prevention of stress. Stress is viewed as an interaction between the individual and the environment. Both need to be targeted for change. At an individual level clients may be taught what to say to themselves and how to respond in situations that they find difficult. At an environmental level the client might be encouraged to organize with others, say, a change in their shift pattern that was more conducive to the workers' interests.

Problem-solving The problem-solving therapies suggest that it is clients' deficiencies in problem-solving that lead to the development and maintenance of their disturbance. Problem-solving therapy (Nezu et al., 1989) has been the most widely applied therapy in this category. Problem-solving is conceptualized as involving the following stages:

(a) problem orientation, i.e. 'locking on' to a problem;
(b) precise definition of the problem;
(c) the generation of as many alternative solutions as possible;
(d) choosing the best solution;
(e) planning implementation of the solution;
(f) reviewing progress.

If the chosen solution has not remedied the problem or only partially so, another 'solution' is chosen, implemented and subsequently reviewed. This approach can be applied to both impersonal and interpersonal problems.

Cognitive restructuring The two main therapies under this category are rational emotive behaviour therapy (REBT; Dryden, 1990) and cognitive therapy (CT; Beck et al., 1979).

REBT contends that irrationality is a major determinant of emotional disorder. Ellis (1962) has suggested that much of the neurotic person's thinking is dominated by 'musts', 'shoulds', 'oughts' and 'have to's'. From the inappropriate use of these moral imperatives, three beliefs may develop:

1 'Awfulizing', which is the tendency to make grossly exaggerated evaluations of negative events.

2 'Low Frustration Tolerance', which is the tendency to believe that uncomfortable situations are impossible to bear.
3 'Damnation', which is the tendency to evaluate as 'bad' the essence or human value of self and/or others as a result of the individual's behaviour.

In CT it is maladaptive interpretations of situations that are viewed as exercising a pivotal role with regard to emotional distress rather than irrational beliefs. Beck, Freeman and Associates (1990) contend for example that an interpretation of a situation that was adaptive in childhood may become maladaptive in adulthood. For example, an abused child may well conclude on the basis of his/her experiences that adults should be approached with great caution, and this may lead to an unnecessary timidity with other people when he or she becomes an adult.

In CT clients are asked to collect data on their current maladaptive interpretations of situations. These interpretations are then cross-examined and if possible tested out empirically. Thus the counselling psychologist may, say, seek to lift a depressed client's mood by tackling the latter's inactivity. However, the client might protest that there is little point in activity because there will be no enjoyment. Rather than get into an argument with the client as to whether he will or will not enjoy the activity, in a spirit of what Beck terms collaborative empiricism, the counselling psychologist might suggest trying the activity as the only sure way of finding out how it influences mood.

Structural cognitive therapy In structural cognitive therapy (Liotti, 1986) the concern is with 'deep' structures. Three levels of cognitive organization are posited:

1 **Core level** – beliefs (schemata) of the individual that have been formed, usually during childhood and adolescence, and that are tacitly held by the individual as unquestionable assumptions about some important aspect of self and reality.
2 **Intermediate level** – verbalizable, explicit descriptions of the self, other people and the world.
3 **Peripheral level** – the plans of action and problem-solving strategies that each individual is able to develop in the day-to-day confrontation with the environment.

A primary concern in structural cognitive therapy is to make explicit the core level. The treatment, for example, of an agoraphobic client would begin with behavioural strategies of helping the client to try going gradually greater distances alone but therapy would not be terminated

when the client had learnt to travel alone. Therapy would also explore deeper issues such as 'who am I getting out and about for anyway?' In addition, developmental origins of the disorder would be explored; for example, an adult agoraphobic may have had a very unwell mother as a child and found that he regularly had to leave her behind to stay with a variety of relatives.

The time scale for the application of the first three categories of CBT is brief compared to traditional psychotherapy, typically involving weekly sessions over three to four months. However, the time scale for the fourth category, structural cognitive therapy, is considerably longer, typically 18 months, because its goal is to achieve such fundamental changes in the individual. In many ways structural cognitive therapy reflects the recently evolved cognitive-behavioural approach to personality disorders. It is well established that if clients not only have an Axis 1 disorder, such as depression, but also an Axis 2 personality disorder, then they are less likely to respond to psychotherapy. As between one-third and two-thirds of clients presenting with anxiety and depression have a co-existing personality disorder it has been important to develop treatment strategies to take account of this (Scott et al., 1995).

Pretzer and Fleming (1989) have suggested the following guidelines for treating clients with personality disorders. (It should be emphasized, however, that none of the CB approaches for treating personality disorders has yet been empirically evaluated.)

1 Interventions are most effective when based on an individualized conceptualization of the client's problems.
2 It is important for the therapist and client to work collaboratively towards clearly identified shared goals.
3 It is important to focus more than usual attention on the therapist–client interaction.
4 Consider interventions that do not require extensive client self-disclosure.
5 Interventions which increase the client's sense of self-efficacy often reduce the intensity of the client's symptomatology and facilitate other interventions.
6 The therapist should not rely primarily on verbal interventions.
7 The therapist should try to identify and address the client's fears before implementing changes.
8 The therapist should anticipate problems with compliance.
9 The therapist should not assume that the client exists in a reasonable or functional environment.
10 The therapist must attend to his or her emotional reactions during the course of therapy.

11 The therapist should be realistic regarding the length of therapy, goals for therapy and standards for self-evaluation.

The CB approaches to personality disorders are an expression of four trends in cognitive-behaviour therapy, that make dialogue and perhaps integration with other psychotherapies more feasible than hitherto.

1 **Inclusion of non-conscious processes.** There is an acceptance that schemata and personal rules are inferred constructs and not observable behaviours which operate covertly and without awareness, though this does not go as far as acceptance of the notion of a Freudian unconscious.
2 **Emphasis on interpersonal process.** The salient cognitions to tackle in the personality disorders are thought to be those concerned with the view of self in relation to others.
3 **Concern for emotional processes.** Whilst cognitive-behaviour therapists have long accepted the interdependence of cognition and affect there is increasing attention being given to affect as conveying information, and as an action disposition. Affect is given the same status as cognition as a therapeutic means by which the client can become less disturbed.
4 **The importance of the therapeutic relationship.** Whilst a good therapeutic relationship has always been held to be a necessary part of teaching clients the various cognitive-behavioural skills, it is only recently in the treatment of personality disorders that it is coming to be understood as a possible laboratory or microcosm of the client's difficulties.

The nature of the relationship between counselling psychologist and client

Within cognitive-behaviour therapy the therapeutic relationship has received much less attention than the technical aspects of counselling. This has not been because the therapeutic relationship was thought unimportant but rather that it was taken for granted that a good therapeutic relationship was a necessary but not sufficient condition for client change. The cognitive-behaviour therapist would insist that both technical and relationship skills are necessary for client change, whilst some other schools of counselling see only the necessity for the relationship to be considered. The Therapist Client Rating Scale (TCRS; Bennun et al., 1986) has been used to assess the client's view of therapy sessions and also the counsellor's view. The client form consists of three scales:

1 Positive regard/interest
2 Competency/experience
3 Activity/guidance.

The counsellors form also consists of three scales:

1 Positive regard
2 Self-disclosure/engagement
3 Cooperation/goal orientation.

Both forms are made up of 29 items with each item scaled 1 to 6 (e.g. 1 = very talkative to 6 = very quiet). The instrument has been used with phobic and obsessive–compulsive clients and a significant positive correlation was found between the client factor 'positive regard' and outcome of therapy.

Counsellors providing cognitive therapy for depression are assessed in research trials using the Cognitive Therapy Scale. The scale has three parts. Part 1, General Therapeutic Skills, and Part 2, Conceptualization, Strategies and Techniques, are of equal depth reflecting the equal weighting given to the personal and technical in cognitive therapy. Part 3 is a brief section in which the rater indicates any additional considerations, for example a particularly difficult client, to be taken into account when rating the quality of the interview. The headings from Part 1 of the Cognitive Therapy Scale are shown below and the extent to which the counsellor met the goal for each heading on a scale 0 to 6 indicated: 0 = poor; 1 = barely adequate; 2 = mediocre; 3 = satisfactory; 4 = good; 5 = very good; 6 = excellent.

Cognitive Therapy Scale

Part 1 General Therapeutic Skills

1 Agenda (0–6)
Therapist worked with client to set an appropriate agenda with target problems suitable for available time. Established priorities then followed agenda.

2 Feedback (0–6)
Therapist was especially adept at eliciting and responding to verbal and non-verbal feedback throughout the session, e.g., elicited reaction to session, regularly checked for understanding and helped summarize main points at end of session.

3 Understanding (0–6)
Therapist seemed to understand the client's internal reality thoroughly

and was adept at communicating this understanding through appropriate verbal and non-verbal responses to the client, e.g. the tone of the therapist's response conveyed a sympathetic understanding of the client's 'message'. Excellent listening and empathic skills.

4 Interpersonal effectiveness (0–6)
Therapist displayed optimal levels of warmth, concern, confidence, genuineness and professionalism appropriate for this particular client in this session.

5 Collaboration (0–6)
Collaboration seemed excellent. Therapist encouraged client as much as possible to take an active role during the session, for example by offering choices, so they could function as a team.

6 Pacing and efficient use of time (0–6)
Therapist used time very effectively by tactfully limiting peripheral and unproductive discussion and pacing the session as rapidly as was appropriate for the client.

Thus in the treatment of Axis 1 disorders the therapeutic relationship has been an important, albeit infrequently discussed, aspect of the counselling process. With regard to the counselling of Axis 2 personality disorders the role of the therapeutic relationship assumes an even greater importance. For example, if a client has an avoidant personality disorder, the key feature of the disorder is that others are seen as critical and demeaning; the therapeutic implication of this is that the counsellor can very easily be cast as 'just like all the others' and special care has to be taken to elicit from the client whether anything has been said or done by the therapist that has upset them. By contrast, a less solicitous stance would be needed with a client with a dependent personality disorder, where the key feature is a belief that they cannot function independently. Thus the counsellor's approach to the relationship is not uniform across the personality disorders.

Family, group and organizational applications

The reciprocal interaction of cognitions, emotions, behaviours and physiology, shown in Figure 7.1 above, takes place in an environment which may to varying degrees be toxic. The individual may 'inhale' the fumes through any or a combination of the four ports of entry – cognitions, emotions, behaviours and physiology. The cognitions port is

always implicated in emotional distress, though the cognition need not necessarily be conscious, as it is now well established in cognitive psychology that people do process information outside of conscious awareness.

The environments which have so far been given consideration in cognitive-behaviour therapy are current partner or family and the organizational environment at work. These are now considered in turn.

Current partner and family

In some instances it is recognized that it may be more appropriate to target the faulty cognitions in the environment rather than the individual. For example, a depressed child might be better helped by the counsellor challenging maladaptive family constructs (i.e. family-held beliefs) with his/her parents and perhaps siblings. So that though the target for change is the child's symptoms, the most efficient way forward might be to challenge the reasonableness of the parents' expectations of him/her and what they communicate to him/her about his/her worth. Cognitive family therapy may in such circumstances be the best way forward. Even in instances of adult depression, marital therapy may be the counselling modality of choice rather than individual therapy. It has been found that 50 per cent of women with depression have severe marital problems, and that the provision of cognitive-behavioural marital therapy, to couples willing to participate, not only improves marital satisfaction but also lifts depression. By contrast, providing individual cognitive therapy to depressed women whilst lifting the depression does not improve marital satisfaction (O'Leary and Beach, 1990).

Cognitive-behavioural marital therapy involves behaviour exchange contracts, practice in communication skills and the challenging of beliefs that disrupt relationships (see Scott, 1989). The beliefs targeted for change in cognitive-behavioural marital therapy tend to cluster under five headings.

1 **Disagreement is destructive**: 'When my partner and I disagree, I feel like our relationship is falling apart.'
2 **Mindreading is expected**: 'People who have a close relationship can sense each other's needs as if they could read each other's minds.'
3 **Partners cannot change**: 'Damage done early in relationships probably cannot be reversed.'
4 **The sexes are different**: 'Misunderstandings between partners generally are due to inborn differences in the psychological make-up of men and women.'
5 **Sexual perfectionism**: 'I get upset if I think I have not completely satisfied my partner sexually.'

Organizations

The most popular model of stress is a transactional one, that is, stress resides neither in the individual nor in the environment, but arises when there is a poor fit between the individual and the environment. Within the work context, stress can arise at the individual (I)/organization (O) interface. By organization is meant the immediate line managers of the individual, who may act as conduits of the organization's belief system. Richman (1988) has contended that individuals may possess vocational irrational beliefs (VIBS) and that the nature of these will be different at various points of the career cycle. Similarly, organizations may be purveyors of VIBS. A list, by no means exhaustive, of I/O VIBS is shown below.

Vocational Irrational Beliefs (VIBS)

At entry

1 'I have to show my boss I can do an excellent job or I will be a failure.'
2 'If I do not like the post right away I will never find a post that is for me.'
3 'I am bright and talented and therefore should not have to do the mundane jobs.'
4 'I cannot stand not using my potential.'

VIBS of a demoralizing boss

1 'New recruits must learn the job slowly, going through every single step.'
2 'New recruits cannot have anything to contribute and therefore should not have their views considered.'
3 'Beginning recruits should do as we say and not ask questions or expect feedback unless we choose to give it.'
4 'New recruits should be given the easiest tasks.'
5 'New recruits should be tested out by being assigned to do the most difficult tasks right away.'

Mid-career

1 'I should have achieved a higher position by this age in my life.'
2 'I cannot stand that I may never accomplish my career goals.'
3 'I am worthless as a person because others of my age have gone further.'
4 'I cannot stand looking after younger workers who may move up beyond my position.'

5 'I should not level off in my career or redefine my goals because this will mean I am weak and not ambitious enough.'

Organizational VIBS

1 'He/she has done well enough in their specialism, they should not want to make any kind of change.'
2 'He/she has too many concerns about their family, they can no longer be trusted as a committed member of the Company.'
3 'He/she should not suddenly try to make a name for themselves at this stage in their career.'
4 'I should not offer him/her any growth opportunities since their time here is limited.'
5 'Mid-career workers seem too conflicted and unmotivated to be given any challenging assignments.'

Resolving many of the so-called 'personality clashes' within industry is actually about identifying and modifying individual and organizational VIBS.

Group

The cognitive-behavioural approaches that have been described for Axis 1 disorders are essentially psycho-educational and lend themselves easily to group treatment. The intent in group cognitive-behaviour therapy, it should be noted, is different from other group psychotherapies where the focus is on group processes and dynamics. The group cognitive-behavioural approach is commended because it is seen as a cost-effective way of bringing about change. For example, Scott and Stradling (1990) have demonstrated that group cognitive therapy for depression produces as much change as individual cognitive therapy. Group cognitive-behavioural programmes have also been described for anxiety and bulimia. Given the scarcity of counsellor resources and long waiting lists in the UK, group cognitive-behavioural approaches are likely to become more commonplace, with counsellors having difficulty making time for the lengthier individual CBT treatments of personality disorders developed primarily in the United States.

Research evidence about efficacy

There is now no disorder to which cognitive-behaviour therapy has not been applied, including teaching psychotic clients to control their

symptoms. But this is not to say that CBT is of demonstrated efficacy for all disorders; with many disorders systematic evaluations have only just begun. At least, however, with regard to CBT a beginning has been made to answer the basic research question posed by Paul (1967), 'What treatment works best, with which clients, under what circumstances, delivered by whom?' The most numerous outcome studies at present relate to depression and anxiety, and the results of these are briefly summarized now.

Depression is the most extensively researched disorder to which CBT has been applied. An analysis of 29 randomized controlled trials (Depression Guideline Panel, 1993) suggested that in acute treatment the efficacy of cognitive therapy was 47 per cent, of interpersonal therapy was 52 per cent (based on one trial only) and of brief dynamic psychotherapy was 35 per cent. However, there was a trend for cognitive therapy to have a lower relapse rate than interpersonal therapy (Shea et al., 1992). Indeed, cognitive therapy appears to have approximately half the relapse rate of antidepressant medication (Evans et al., 1992).

Numerous studies have attested to the efficacy of exposure treatment for agoraphobia, and it has been shown to be superior to a variety of credible 'placebo' interventions (Mathews et al., 1981). Though the graded exposure to feared situations is overtly a behavioural strategy, there are implicit cognitive strategies, about for example the conceptualization of 'failure' experiences. The typical finding is that two-thirds of clients are substantially improved, though even in these some disability remains.

Most clients with agoraphobia also experience some episodes of panic, and panic disorder has become a focus of treatment in its own right. The key elements in the treatment of panic are:

1 Systematic exposure to somatic sensations associated with panic (for example, those associated with hyperventilation, overbreathing).
2 Challenging catastrophic misinterpretations of bodily symptoms.
3 (Usually) breathing retraining.

For panic disorder clients who do not have severe agoraphobic avoidance, that is mild/moderate agoraphobic avoidance, the typical finding is that 90 per cent become panic free after 12 one-hour sessions of cognitive therapy, whereas the comparable figures for applied relaxation training are 50–55 per cent, and for clients on a waiting list 5 per cent. These changes have been found to be maintained at one-year follow-up. For panic disorder clients with only mild agoraphobic avoidance, applied relaxation training and cognitive therapy seem to be roughly comparable. In one study (Telch et al., 1993), involving a comparison of 12 sessions of group cognitive-behaviour therapy for panic disorder over an eight-

week period with a delayed treatment control, at six-month follow-up 63 per cent of the treated patients had recovered compared to 9 per cent of controls.

For generalized anxiety disorder Butler et al. (1987) have developed a treatment package that consists of:

(a) information about the nature of anxiety and what to expect from treatment;
(b) a cognitive component to address specific anxiety-producing thoughts;
(c) distraction and relaxation techniques for anticipating anxiety;
(d) *in vivo* exposure to avoided situations; and
(e) a component focusing on increasing self-confidence, which includes identification of the client's strengths and areas of competence and identification of and increase in enjoyable activities.

They found their anxiety management programme superior to a waiting-list control condition at post-test and clinically significant gains were maintained at follow-up. However, in trials where such programmes have been conducted but without the *in vivo* exposure component, the anxiety management clients have only fared as well as those given non-directive counselling.

Counselling psychologists can become dismayed that their clients may not seem to do as well as those in published controlled trials. One of the reasons for the 'apparent failure' is that clients with a mixed diagnosis are deliberately screened out from trials. For example, a depressed client with a drink problem would be excluded from a controlled trial of depression. As such the exclusion criteria of controlled trials have to be carefully examined. They may, for example, exclude panic patients who are housebound or those with a personality disorder. Nevertheless, in a consecutive series of 100 referrals the first author found that in primary care, 67 per cent met inclusion criteria, depression (23 per cent), generalized anxiety disorder (25 per cent) and panic disorder (19 per cent). It is then possible to use the results of outcome studies to evaluate the majority of cases seen by a counselling psychologist. There is, however, another difference between controlled trials and counselling psychology in practice that has to be taken into account, which is of ensuring that the client has an adequate 'dose' of counselling. In a controlled trial 'the dose of therapy' is guaranteed: however, the counselling psychologist in practice has to contend with the pressures of the waiting list and may often be only able to deliver one-half the number of sessions delivered per patient in trials. Accordingly the degree of change expected has to be scaled down. It may be that the norm for depressed patients by the seventh session should be a 25 per cent reduction in Beck

Depression Inventory score. (This can also serve as a marker for progress when it is possible to provide more sessions.) For generalized anxiety disorder a 25 per cent reduction in Beck Anxiety Inventory score by the seventh session may be the appropriate norm.

The continued existence of counselling psychology will probably depend on its ability to produce demonstrable change and establish an adequate methodology of audit. One of the advantages of the cognitive-behavioural approach in this connection is the careful explanation of procedures and the many areas in which it is already of demonstrated efficacy.

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