

learning zone

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Cognitive behavioural therapy for patients with anxiety and depression

NS365 Curran J et al (2006) Cognitive behavioural therapy for patients with anxiety and depression.
Nursing Standard. 21, 7, 44-52. Date of acceptance: August 29 2006.

Summary

This article describes and explains the theoretical background of cognitive behavioural therapy. The evidence base for the cognitive behavioural treatment of a number of mental health problems is reported and the principles of effective treatment described.

Authors

Joe Curran is principal cognitive behavioural psychotherapist, Sheffield Care Trust; Catherine Machin is clinical lecturer/cognitive behavioural psychotherapist, Sheffield Care Trust, Sheffield; Kevin Gourlay is professor of psychiatric nursing, Health Services Research Department, Institute of Psychiatry, King's College London. Email: joe.curran@sct.nhs.uk

Keywords

Cognitive behavioural therapy; Depression; Mental health

These keywords are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review. For related articles and author guidelines visit our online archive at www.nursing-standard.co.uk and search using the keywords.

- ▶ Identify recent developments in cognitive and behavioural therapies.

Cognitive behavioural therapy

CBT is used to describe a number of approaches to understanding and the psychological treatment of a range of mental health problems. The term is best used to describe an approach characterised by a set of shared philosophical assumptions about the cause and treatment of psychological distress, rather than one individual form of treatment. Individual therapies, so-called 'brand name therapies', are encompassed by the term CBT, along with some specific treatment techniques (Box 1).

In the treatment of psychological problems each of these approaches will usually highlight a person's behaviour, thoughts (or cognitions), or physical symptoms, for example, panic. There are differences in the relative importance each approach places on these areas, and the theories that are used to explain how problems develop.

There are CBTs that are routinely recommended for a range of psychological problems encountered in clinical practice, especially those associated with anxiety and depression. Anxiety disorders for which CBTs may be useful are specific phobias, panic disorder and agoraphobia, obsessive compulsive disorder (OCD), generalised anxiety disorder, post-traumatic stress disorder (PTSD) and body dysmorphic disorder (Department of Health 2001, National Institute for Clinical Excellence (NICE) 2004a). There is evidence that CBT is most effective for patients experiencing mild to moderate depression (NICE 2004b). However, therapy approaches are available for more severe depression

Aims and intended learning outcomes

The aims of this article are to educate nurses about the theoretical background of cognitive behavioural therapy (CBT) and enable them to consider the application of CBT principles in their practice. After reading this article, you should be able to:

- ▶ Summarise what is meant by the term CBT.
- ▶ Describe the 'five areas' model of assessment and treatment.
- ▶ Outline the key features of CBT.
- ▶ Discuss the main CBT treatment approaches used with anxiety and depression.

(Dimidjian *et al* 2006). In areas that overlap with physical health, CBTs have been applied to chronic fatigue syndrome, chronic pain, irritable bowel syndrome, health anxiety and non-epileptiform seizures. CBTs have also been developed that focus on delusions, hallucinations, schizophrenia and bipolar disorder.

Time out 1

Examine the list in Box 1. How many of these treatment approaches are you familiar with? For those you are not familiar with, the following websites may be useful:
www.babcp.com, www.wikipedia.com,
www.webmd.com

In the UK, cognitive and behavioural psychotherapy is delivered by mental health professionals who have undertaken specialised training and supervised practice. Grant *et al* (2004) identified a range of factors to be considered by those wishing to acquire expertise in CBT and develop the implementation of CBT in their workplace, including the requirement of clinical supervision of practice.

BOX 1

Examples of cognitive behavioural therapies

'Brand names'

- ▶ Cognitive therapy
- ▶ Behaviour therapy
- ▶ Rational emotive behaviour therapy
- ▶ Acceptance and commitment therapy
- ▶ Dialectical behaviour therapy
- ▶ Schema-focused therapy
- ▶ Social skills training
- ▶ Anxiety management
- ▶ Problem-solving therapy
- ▶ Stresspac
- ▶ Cognitive processing therapy
- ▶ Mindfulness-based cognitive therapy
- ▶ Panic control treatment
- ▶ Motivational interviewing

Treatment techniques

- ▶ Exposure, including in vivo exposure and imaginal exposure
- ▶ Exposure and response prevention
- ▶ Behavioural activation
- ▶ Habit reversal
- ▶ Cognitive restructuring
- ▶ Behavioural experiments
- ▶ Relaxation training

History

In the 1970s cognitive and behavioural approaches were integrated into the understanding and, more importantly, treatment of human psychological problems. This was informed, in part, by Lang's (1977) bioinformational theory of emotion in which he proposed that it was useful to think of three loosely related response systems that make up fearful responses: cognitive/informational, behavioural/motoric, and physiological/affective. Adopting this approach enabled practitioners and researchers to consider events taking place inside the individual and explore their effect on feelings and behaviour.

These response systems are now referred to as thoughts, feelings and behaviour, and are essential components of contemporary cognitive behavioural frameworks. One such framework is the five areas approach advanced by Williams (2001), which describes the five areas of interest to CBT practitioners as mood, behaviour, thinking, physical symptoms and environment (Box 2).

Time out 2

Think about a patient with whom you have recently worked. Identify the key aspects of his or her experience and then organise these into the areas identified by the five areas approach. Do you find this approach helpful? Are there any apparent limitations?

Behavioural approaches

Behavioural approaches are identified with theories of conditioning. Pavlov (1927) and Watson and Rayner (1920) were used to inform theories of how fears developed – known as classical conditioning – in which events that previously evoked no reaction came to produce fearful responses through their association with anxiety-provoking events.

Skinner (1938) was used to explain how other aspects of learning – called operant conditioning – could explain the maintenance of anxiety. Skinner proposed that behaviours that are followed by consequences which benefit the organism are more likely to occur again and account for the persistence of certain aspects of behaviour.

The principles of classical and operant conditioning are still used to help understand how and why anxiety and depression persist, but they are unable to explain the complexity of human experience. For example, while classical and operant conditioning theories can still be applied to the development and maintenance of some anxiety disorders, they are unable to account for the effect of beliefs, attitudes, memory, motivation and perception of behaviour.

Cognitive approaches

Cognitive approaches explore the meanings that we attach to our experience, the assumptions that we make about the world, others, the future and ourselves, and the attributions we make. While this may be complex, cognitive therapists become skilled in helping people understand the meanings they attach to events and the effect this has on their emotions and subsequent behaviour. In patients who experience anxiety-related problems, specific themes of threat or danger may be present, along with a reduced estimation of ability to cope. In patients experiencing depression, themes of low self-esteem, pessimism, hopelessness, helplessness and guilt may be evident in their representations of themselves and their world.

The most well known and researched cognitive approach is Beck *et al's* (1979) cognitive therapy, which was initially developed to treat depression. Since the 1970s cognitive therapy has been adapted to work with an increasing range of difficulties, for example, panic (Clark 1986), OCD (Salkovskis

1989) and personality disorders (Davidson 2000).

Cognitive therapy's central tenet is that thinking processes are influenced by, and influence emotions, physical symptoms and behaviour. Individuals are not passive recipients of environmental and physical sensations but actively construct their personal meanings (Wells 1997). Beck *et al* (1979) identified three levels of thoughts: automatic negative thoughts, conditional assumptions and core beliefs.

Automatic negative thoughts These can be defined as thoughts or mental images that people may not be aware of unless they focus their attention on them (Beck *et al* 1979). They are often an appraisal of events from the past, present and future and can be seen as a habitual pattern of thinking. Because the thoughts are automatic and habitual, people often view them as believable and factual, never considering alternative perspectives. This leads them to respond emotionally and behaviourally as if their thoughts were true, so, for example, they feel anxious if they think a situation is dangerous even if it is not.

Conditional assumptions These are rules that are learned through experience and may have been useful at some stage of human development. However, they become problematic if they are rigid and do not evolve in response to later experiences. Assumptions are often socially reinforced, for example, gender stereotypes. They are conditional, for example, 'If I say "no", others will not like me and reject me,' and result in the person responding as if they are facts, for example, by always saying 'yes'. By behaving in this way they do not find out if their rules and assumptions are true or not, for example, saying 'no' and finding out that people do not reject them.

Core beliefs These beliefs are enduring and long-standing. They are rigid, not easily accessed, seen as fact, and impervious to challenge and re-evaluation by experience. The themes of beliefs are associated with helplessness, 'unloveability', danger and vulnerability, and are directly represented in the content of conditional assumptions and automatic negative thoughts.

OCD, in which patients experience intrusive thoughts of harm, danger or contamination, is an illustration of this. Earlier accounts of OCD suggested that specific thoughts or stimuli became associated with distress through classical conditioning, with escape, avoidance and the performance of rituals being key features of the disorder and becoming established because they resulted in relief from distress (Steketee 1993).

However, when cognitive theorists explored OCD, they suggested that many people had a sense of inflated responsibility for negative events. They believed that if they thought something it meant it was likely to happen and, if it did, then it would be their fault (Salkovskis 1989). The

BOX 2

The five areas approach

Altered mood: this area refers to a person's description of his or her emotional experience, such as sadness, anger, fear or despair.

Altered behaviour: this area explores the actions people do or do not do when anxious or depressed. In some circumstances it is important to highlight the effects that some actions have, for example, that they may bring short-term relief, but may not be effective in the long term. In the five areas approach these are called 'unhelpful behaviours' and may include reassurance seeking, shopping, drinking or drug taking.

Altered thinking: specific thoughts or thinking patterns may be identified. The most important of these are termed 'extreme and unhelpful thinking' which are most likely to lead to difficult emotions. Specific extreme and unhelpful thinking styles include 'bias against myself', putting a negative slant on things' (negative mental filter) and 'making extreme statements and rules'.

Altered physical symptoms: this area explores the physical sensations that patients experience when distressed or anxious. In patients who are anxious this may include: dry mouth, rapid heart rate, palpitations, muscle tension, nausea and a choking sensation. In patients with depressed mood this area may include reduced appetite, lack of energy, poor sleep and low sexual interest.

Environment - life situation, relationship and practical problems: consideration of patients' environmental context is crucial. Specifically, the quality and nature of relationships is explored, along with other aspects of their life situation that may be associated with distress. It is important to remember here that a range of situations may act as triggers to psychological distress, such as job loss or bereavement, and that a number of areas of life might be affected by psychological problems, such as a prolonged depression leading to loss of job.

(Williams 2001, 2004)

resultant compulsions were, therefore, aimed at reducing the likelihood of the event happening, for example, hand washing preventing perceived contamination, and thereby decreasing their responsibility if it was to happen. In contemporary cognitive and behavioural therapy for OCD, treatments that encompass behavioural and cognitive approaches are generally used.

The therapy process

CBT is often described as a short-term, structured psychotherapy (Hawton *et al* 1989). Generally, treatment takes place over 12 to 20 sessions and is directed towards helping the patient reach explicit goals agreed at the start of therapy.

The therapeutic relationship in CBT The development of a sound, working relationship in which warmth, trust, genuineness and empathy are present is a hallmark of good cognitive behavioural practice. However, for CBT to be effective it is argued it should also include specific techniques based on a sound rationale with attention to the patient's individual history and goals (Waddington 2002). Key to the ongoing therapeutic relationship in CBT is 'collaboration', in which the therapist and patient agree to work together to help the patient reach explicitly stated goals. This requires the therapist to convey that he or she understands the patient's situation and perspective and is able to enable people to make the changes in their lives that they wish to make for themselves rather than be overly directive.

Structure CBT is psychotherapy in which attention is paid to the structure of individual sessions and the overall process.

On average, CBT takes 12 to 20 sessions. For some patients with specific problems as few as five sessions may be sufficient to initiate change, whereas for others with longer term and more complex problems up to 50 sessions may be required. It is possible to identify separate and distinct stages of treatment.

Assessment First, the therapist and patient work together to assess the nature and extent of the problem, and to identify the goals of treatment. Generally, two assessment processes are used.

The first is known as a presenting problem assessment in which the main details of the patient's problem are specified, along with the factors that may influence it day-to-day. It is common in routine CBT for patients to have a screening session in which the presenting problem is assessed and information on likely treatment approaches provided. This is so the patient and therapist can reach a decision about whether therapy is indicated and whether the patient wants to participate in therapy.

The second assessment is more detailed. It covers the patient's medical, psychiatric, personal, social, educational, occupational and relationship

history, as well as current circumstances. These factors will be considered when planning an individualised treatment programme.

Formulation Second, a formulation or conceptualisation of the problem is developed to help the therapist and patient understand how the problem developed and why a problem persists. The formulation will lead to the development of a treatment plan in which the therapist identifies and explains the activities that may help the patient to reach his or her goals. Developing a collaborative treatment plan requires that therapists have a sound knowledge of evidence-based approaches to psychological problems, and can combine this knowledge with an awareness of, and sensitivity to, the individual patient.

For some, the formulation process is a hallmark of psychotherapeutic practice. Therapy without formulation, such as the use of treatment manuals that specify the steps to be taken in therapy for every person with a particular problem or disorder, may lack the appropriate sensitivity and specificity to the individual. In accord with the principles of collaboration, the formulation is always made explicit to the patient and is always negotiated. The therapist shares his or her understanding of the problem and likely solutions with the patient so a shared understanding of what led to the problem, what is keeping it going, and what may be changed is reached together.

Treatment Although the specifics of each session will vary according to the type of problem the patient is experiencing and their goals, there are some characteristics common to CBT sessions. Each session will include the development of an agenda that will detail the work to be done in the time available. Agendas are set collaboratively so that the therapist and patient can each contribute items that they would like covered. In the early stages of treatment it is typical for the therapist to be more active in introducing agenda items, with the patient becoming increasingly responsible for agenda items in later stages.

While the content of each session will differ, some hallmarks of good practice should be evident in all sessions. In CBT there is a role for educational interventions, such as explaining what is known about the adrenaline response to someone who experiences panic, that seek to raise the patient's awareness of the nature of therapy, and the knowledge base for effective interventions. In CBT the patient is informed about evidence-based approaches to therapy. These are openly discussed and the 'therapist-as-expert' position is avoided.

The therapist will usually use methods of guided discovery, or Socratic dialogue, that enable patients to develop their awareness of the unhelpful cognitive and behavioural processes they engage in, along with identifying alternatives that can help them move towards making the

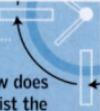
desired changes in their life.

Homework – preferably described as ‘work to be done between sessions’, or ‘putting into practice what has been learned’ – is generally agreed between the patient and therapist near the end of each session. The main learning of the session is reviewed and the patient is given the opportunity to implement a change strategy in their everyday life. It is important that the work agreed is reviewed at the next session.

Ending and evaluation Once the patient has engaged with the therapy process and started working towards their goals, the therapist and patient begin to think about an appropriate point to end treatment. It is often unnecessary to wait until the patient has achieved all of his or her goals if he or she is demonstrating progress. Cognitive behavioural therapists will typically use individualised measures, such as goal statements and targets, along with broader questionnaires and rating scales that can be used to monitor progress and assess change.

Time out 3

Examine the key features of the therapy process just described. How does this compare with your practice? List the similarities and differences. Are there opportunities here to enhance your practice in any way?



Treatment approaches

Exposure-based therapies Exposure can be defined as ‘facing something that has been avoided because it provokes anxiety’ (Hawton *et al* 1989). Exposure-based therapy is an evidence-based treatment for specific and social phobias, OCD and PTSD. The principles of exposure are deceptively simple and are commonly described as ‘face your fear’. While this maxim is a good general description of the underlying principle of exposure therapy, other factors need to be considered. Three of the most important are that exposure therapy should be graded, repeated and prolonged.

Graded This enables people to habituate to feared objects or situations one step at a time. First, patients are asked to identify all situations or objects that make them afraid. Then they are asked to list these in order, usually with reference to the amount of fear or anxiety they evoke. A common scale to help is the Subjective Units of Discomfort Scale (SUDS), where each item on the list is given a score of between 0 (no discomfort) and 100 (maximum discomfort)

(Wolpe 1991). All of the listed items are then ordered into a hierarchy that forms the basis of therapy.

Repeated It is unlikely that exposure-based treatments will be successful if a patient carries out only one exposure session with the object or situation, or undertakes one session a week during appointments with the therapist. For exposure to have the greatest chance of success, it is necessary for patients to continue the work done in sessions on a daily basis. Several studies suggest that therapy in which patients do not carry out their exposure tasks as homework is less successful (Marks 1987).

Prolonged Habituation is the underlying rationale of exposure therapy. It refers to a common physiological process in which repeated presentation of a stimulus leads to a reduction in responses previously associated with the stimulus. It can be described as a ‘getting used to’ process. The knowledge that anxious or fearful responding, based on the release of adrenalin, is a short-term fight or flight reaction is important. In response to a single trigger situation this response lasts around 50 minutes before it starts to tail off. Thus, if we remain in the presence of something that frightens us for around 50 minutes, the fear response we experience is likely to lessen. What was frightening becomes less so and the next time we encounter it we are likely to get anxious, but not as anxious as the previous time. If we continue to expose ourselves to things we are frightened of, and choose to remain in their presence until the fear has reduced, we are taking important steps to reducing the impact of fear on our lives (Box 3).

Variants of exposure Systematic desensitisation describes the process of helping people reduce their fears. In CBT it refers to a specific therapeutic process developed by Wolpe (1958, 1991) in which patients with fears and phobias were trained in relaxation and then asked to think about the objects or situations of which they were fearful while remaining relaxed. In this way, patients were then able to associate their feared situation with relaxation and overcome their fears.

Flooding This refers to an approach where patients begin therapy by facing situations that are at the top of their hierarchy of fear rather than at the bottom.

Implosion This refers to a type of flooding where patients are asked to imagine the worst possible anxiety-provoking situation.

Virtual reality exposure Virtual reality technologies assist in the development of stimuli, such as spiders, flying, heights or even social environments so that therapy can proceed without practical difficulties associated with some phobias. For example, arranging graded and repeated exposure to flying would be time-consuming and expensive.

For more detail on the applications of these

approaches to specific clinical problems, refer to Rogers and Liness (1999) (PTSD), Leahy and Holland (2000), Rogers (2000) (phobias), Curran and Rogers (2001) (trichotillomania), Curran *et al* (2002), Rogers *et al* (2002) (depression), Grant *et al* (2004) and Gournay *et al* (2006) (OCD).

Cognitive treatment interventions

Cognitive therapy for depression This is a multi-component treatment that focuses on key aspects of behaviour and thinking to help people overcome their depression.

Following assessment, initial intervention focuses on behavioural change. A depressed patient is often caught in a cycle of reduced activity which leads to an increase in automatic negative thoughts and physical symptoms of depression. Therefore, the therapist aims to introduce behavioural change to:

- ▶ Increase pleasurable activity.
- ▶ Increase level of activity.
- ▶ Challenge automatic negative thoughts.
- ▶ Increase mood.

The therapist introduces:

- ▶ Activity monitoring – the patient is asked to monitor his or her activity over a week. The patient and therapist collaboratively review the week and identify any patterns of behaviour that could be seen as helpful or unhelpful to the maintenance of their depression.
- ▶ Activity scheduling – the therapist and patient

plan specific activities for one day. This allows them to plan structured achievable goals for the day. The therapist or nurse then negotiates with the patient to plan activities and carry these out for the remaining days of the week.

- ▶ Following each activity the patient is requested to rate activity for pleasure and mastery (a sense of achievement) on a 0-10 scale. This allows the patient to recognise partial success, pleasurable emotions and challenge 'all or nothing' thinking. The process supplies the therapist and patient with information to identify and challenge cognitive distortions.
- ▶ Graded task assignment. Activities that have been avoided because they were perceived as too difficult or complex are broken down into smaller steps. The patient is helped to carry out each component of the task one step at a time. This technique is useful with patients who tend to approach tasks from an 'all or nothing' point of view. It is important to help the patient focus on the successful implementation of each step.

The behavioural activation phase of cognitive therapy for depression lasts about five weeks. When more effective behavioural patterns are being developed the therapist and patient explore the area of thinking in more detail. One benefit of the behavioural activation phase of therapy is that patient and therapist will have developed an awareness of specific thoughts, or thinking styles that may be associated with depressed mood and avoidance. For example, following attempts to engage in more meaningful activity, specific predictions about failure may be evident, or following tasks that went reasonably well

BOX 3

Case study one: exposure as a main treatment for arachnophobia

Wanda had a lifelong fear of spiders. Symptoms included rapid heart rate and breathing, sweating, trembling and muscle tension. She would rapidly leave the area if she encountered a spider. She avoided dark spaces, lofts, sheds or spaces behind furniture, and she often asked people to check rooms before entering them to make sure there were no spiders around. The problem was having a significant effect on her ability to live her life.

CBT consisted of graded exposure and lasted for six sessions. Wanda was initially asked to identify all stimuli that triggered anxiety and to put these in order from most anxiety provoking to least anxiety provoking. From her hierarchy it was evident that the larger and hairier spiders were, the more anxious she would feel, and that the nearer she got to spiders of all sizes the more anxious she would feel. Graded exposure began with introducing her to smaller, relatively hair-free spiders at a distance. At this stage the therapist used dead spiders in a jar as the first exposure item. When Wanda noticed a reduction in anxiety of around 50 per cent from start to finish the exposure session finished and she agreed to take the spider home to rehearse exposure on her own.

At the next session a week later Wanda was able to remain in the presence of the spider with minimal fear and agreed to move onto the next item on her hierarchy – handling a small dead spider. At this session the therapist employed modelling procedures to demonstrate handling the spider, before Wanda tried this herself. Initially she reported high levels of anxiety, urges to leave the room and to avoid looking at the spider. By the end of the session she reported that her fear had reduced. She once again agreed to take the spider home to practise handling it on a daily basis. Therapy continued in a similar fashion, moving up items in her hierarchy, until she was eventually able to handle a large, hairy spider with moderate levels of discomfort, which would have previously produced intense levels of arousal and been avoided.

patterns of only focusing on the negative aspects of situations may be observed.

While the therapist can identify specific thoughts and patterns of thinking, his or her task is to help patients become more aware of these and the effect they have. Thought identification, in which patients are helped to become more aware of their thinking patterns, is the first step towards this. Thought identification may be introduced through the use of specific questions, such as: 'What were you thinking at that time?', 'What were you saying to yourself?', and 'What went through your mind when you felt low?'

Giving the patient a diary to complete outside of the session is helpful. Once the patient and therapist have developed an understanding of the role that thinking plays in the patient's distress, 'thought challenges' are introduced. The therapist and patient work together to examine the specific meanings of the patient's thoughts and explore possible alternatives, through the use of questions such as 'Where is the evidence that this thought is true?' or 'Based on your experience, how likely is that to happen?' Behavioural experiments to determine whether events happen in the way the patient's thoughts indicate they do can also be used to help patients. For example, if a person is making specific predictions about his or her performance in a given situation, for example, 'I can't do that because I'll fail', an experiment that tests this thought might be useful. The therapist's role is to help patients challenge their thoughts, rather than challenge patients' thoughts for them. Depending on the patient's progress, further sessions may focus on conditional assumptions and beliefs.

Time out 4

Recall a patient who is experiencing or has experienced problems with depression and low mood. What treatment approaches were adopted? How do they differ from those just described?

Anxiety-based problems Cognitive interventions for patients with anxiety-based problems also explore the specific meanings that patients attach to situations or objects. Common themes that may be explored may include overestimations of risk or danger and underestimations of ability to cope. Similar techniques to those used with patients who are depressed are adopted, that is, thought identification, thought challenging and behavioural experiments.

In the second case study, Yusuf's CBT explored the two main areas of 'altered thinking' and

'altered behaviour' (Box 4). Although Yusuf's presenting problem was the frequency and intensity of physical symptoms, a cognitive behavioural formulation of his problem suggested that his belief that panic could kill him, his avoidance of anxiety and arousal, and his use of safety-seeking behaviours were central to the maintenance of his problem. Specific techniques used included education about the nature of anxiety and panic, graded exposure to situations that made him anxious and graded exposure to bodily symptoms of anxiety (known as interoceptive exposure), thought identification and challenging and behavioural experiments. Thought challenging aimed to help him weaken the belief that if he experienced a panic attack he was going to die imminently. It was aided by helping him examine the number of times he had experienced the symptoms and thought he was going to die, compared with the reality of the situation – that is, he had experienced panic and he had not died. The behavioural experiments that helped Yusuf tested his thoughts to help weaken his belief in them. He was asked to engage in a physical activity to bring on his symptoms, with a view to examining whether the theory that they were 'difficult but not dangerous' was more true than 'they are a sign of impending death'. The use of these techniques relies on the presence of a sound therapeutic relationship, and the authors would advise against their use in the absence of such a relationship.

Cognitive behavioural therapy developments

In recent years there has been an extension of therapeutic modalities, beyond face-to-face meetings with a therapist on a weekly basis so that practitioners and researchers are becoming increasingly interested in self-help approaches. Books and computers that provide detailed information on methods that patients may adopt to address problems are used. A variety of resources exist, although only a few self-help approaches have been evaluated in research trials.

NICE (2006) recently reviewed computerised self-help for depression and anxiety, and recommended two specific programmes, Beating the Blues (Ultrasis) and FearFighter (ST Solutions). These developments can be incorporated into stepped-care processes, where interventions are delivered on the basis of clinical need, with more complex, time-consuming and intensive therapies offered later in care. Recent developments in this area are the MoodGym (www.moodgym.anu.edu.au), and Living Life to the Full (www.livinglifetothefull.com), which are online resources that encourage the use of self-help techniques for depression and anxiety.

Researchers and practitioners have developed

alternative perspectives to CBT's traditional emphasis on symptom reduction or elimination that explore the use of strategies based on acceptance, where acceptance is defined as 'actively contacting psychological experiences – directly, fully, and without needless defence – while behaving effectively' (Hayes *et al* 1996). The central feature of many mental health problems is 'experiential avoidance' (Hayes *et al*

BOX 4

Case study two: anxiety or panic disorder with agoraphobia

Yusuf was a 45-year-old man who was referred for help with panic attacks. He experienced panic attacks at least once a day during which he would have a full range of physical symptoms, including increased heart rate, rapid breathing, tightness in his chest, sweating, muscle tension, trembling, dry mouth and blurred vision. He reported that the panic attacks came 'out of the blue', but were more likely to occur if he was out of the house unaccompanied. If he noticed a panic attack coming on he would leave the situation he was in and try to get home. When he was having a panic attack he feared that he was having a heart attack. In an attempt to reduce their occurrence he would avoid going too far from home, unless accompanied by a trusted friend, and would also avoid exercise or any other activity that increased his level of physical arousal. He would also carry his mobile telephone with him so that he could summon help if needed. As a consequence of his panic attacks he had stopped working, and had a restricted social life. His relationship with his wife was also becoming strained.

1996), where people attempt to eliminate, control or reduce certain symptoms, for example, anxiety, depressed mood and troublesome thoughts, using a variety of methods, including thought suppression, distraction, alcohol and medication. This results in the person focusing on getting rid of their unwanted symptoms and thoughts, with a consequent reduction in attention to other areas of their life. However, attempts to not think a certain thought may actually increase the frequency with which the thought occurs. Acceptance approaches form a significant part of acceptance and commitment therapy (Hayes *et al* 1999) that has shown promising results with a range of clinical conditions seen in routine clinical practice (Hayes *et al* 2006).

Researchers have explored the use of mindfulness meditation techniques with people who are at risk of developing further episodes of depression. In mindfulness-based cognitive therapy, patients are trained in meditation techniques and, rather than trying to challenge or change the content of their thoughts, are helped to view thinking as a process in which thoughts are 'just thoughts'. This is a change in emphasis from traditional CBT models, as suggested by Segal *et al* (2004): 'Unlike CBT, there is little emphasis... on changing the content of thoughts; rather the emphasis is on changing awareness of and relationship to thoughts.'

The emphasis on psychological theories should also not exclude physical treatments that work, such as medication, and in clinical practice it is relatively common for CBT to be used in

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conjunction with antidepressant medication to provide the best opportunity for improved clinical outcome for the patient. However, anxiety-reducing medications do not generally form part of a cognitive behavioural approach. Additionally, although there is evidence that CBT is effective for a range of conditions, there is marked variation when specific disorders are compared, with enormous gains in some, for example, phobias, and only marginal gains in others, for example, schizophrenia and personality disorders. The challenge is for practitioners and researchers to refine their methods, and evaluate their practice, so that knowledge of what works can continue to be used to improve the lives of those seeking help.

Practitioners

In the UK, the majority of CBT practitioners working in the NHS are qualified mental health professionals who have undertaken further specialist training. Because there are currently fewer therapists than needed, waiting lists are increasingly a feature of NHS service provision. In response to this problem, the government has announced proposals to increase the availability of CBT by training up to 10,000 practitioners (Layard 2004).

Clinical supervision is essential for those carrying out cognitive behavioural interventions. Despite its apparent simplicity, delivering CBT

effectively requires a high level of skill to develop and maintain therapeutic relationships, assessment, formulations and treatment. The techniques described need to be delivered with flexibility and creativity as well as sensitivity to the patient's context and individual needs.

Time out 5

If you were to consider applying CBT techniques in your practice what additional training would you need? Consider the availability of CBT in your area. Where could you access supervision and training? The website of the British Association for Behavioural and Cognitive Psychotherapies might be a useful resource: www.babcp.com

Conclusion

Cognitive behavioural psychotherapy is a structured, time-limited form of psychotherapy that focuses on patients' current problems, proposes solutions that may be carried out in their daily lives and helps patients to make their desired changes in a supportive, collaborative and empowering relationship. There is a substantial and growing evidence base for CBTs and therefore an increasing interest in their use NS

Time out 6

Now that you have completed the article, you might like to write a practice profile. Guidelines to help you are on page 56.

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