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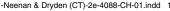## An Overview of Cognitive Therapy

Introduction

Three people working for the same company at the same level and salary are all made redundant at the same time. The first person is angry because she believes she should have been promoted, not sacked; the second person is anxious because he thinks about the financial difficulties that lie ahead; the third person is hopeful because she thinks about the good opportunities that redundancy may lead to. These three different emotional reactions to the same event underscore a key idea in cognitive therapy (CT): namely, that our reactions to events are powerfully influenced by the way we view these events. By 'tapping the internal communications' (Beck, 1976), you can discover the thoughts and beliefs that largely determine your emotional responses to events. Clients are often surprised to learn that they are, in general, responding to their interpretation of the event rather than the event itself, e.g. 'I always thought that being criticized made me angry but, on reflection, what really triggers the anger is my belief that I've been exposed as stupid and incompetent'. To summarize: the way you think affects the way you feel. As Clark and Beck observe (2010: 31), 'This simple statement is the cornerstone of cognitive theory and therapy of emotional disorders.'

Some clients (and therapists) might say that events do directly cause our emotional reactions and, for example, point to everyone being anxious if they were in a burning building. While everyone may well be anxious, some people might be in a wild panic, creating additional dangers for themselves and others; some are frozen in terror; while others are struggling to stay in control in order to find a way out. When
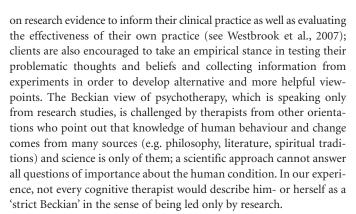
outside, some will calm down and recover more quickly than others from the ordeal, while one or two individuals may go on to develop full-blown post-traumatic stress disorder (PTSD). All have experienced the same event but only by examining each person's viewpoint can you truly understand why they reacted in the way that they did (and, in some cases, continue to suffer from their experiences). CT teaches clients that there is always more than one way of seeing events and, therefore, their viewpoint is largely a matter of choice (Butler and Hope, 1996).[1] Helping clients to develop and maintain more helpful viewpoints in tackling their problems is the focus of therapy.

CT was developed by Aaron T. Beck at the University of Pennsylvania in the early 1960s. Beck's approach initially focused on research into, and the treatment of, depression (Beck et al., 1979). Since then, CT has been applied to an ever-increasing number of clinical problems such as anxiety and phobias (Beck et al., 1985), substance abuse (Beck et al., 1993), schizophrenia (Kingdon and Turkington, 2004), obsessive-compulsive disorder (Clark, 2004), post-traumatic stress disorder (Taylor, 2006), health anxiety (Taylor and Asmundson, 2004), chronic pain (Winterowd et al., 2003), bipolar disorder (Basco and Rush, 2005), chronic fatigue syndrome (Kinsella, 2007), eating disorders (Fairburn, 2008), and working with couples and families (Dattilio, 2010), groups (Bieling et al., 2006), psychiatric inpatients (Wright et al., 1993), personality disorders (Davidson, 2008), children and young people (Stallard, 2002) and older people (Laidlaw et al., 2003).

CT has a strong commitment to scientific empiricism, i.e. testing its cognitive conceptualizations of various disorders (e.g. panic, health anxiety, obsessive-compulsive disorder) and their accompanying treatment protocols (see Clark, 1996, for the steps to follow in the Beckian approach to psychotherapy research). Scientific empiricism is not only a method but also a mindset – the willingness to abandon key CT tenets if not supported by research evidence: 'This is the gold standard to which we hold an "empirically based psychotherapy": a commitment to empirically examine every tenet of the therapy and follow the data, wherever they may lead' (Padesky and Beck, 2005: 188). Therapists are encouraged to adopt the stance of a scientist-practitioner by drawing

on research evidence to inform their clinical practice as well as evaluating the effectiveness of their own practice (see Westbrook et al., 2007); clients are also encouraged to take an empirical stance in testing their problematic thoughts and beliefs and collecting information from experiments in order to develop alternative and more helpful viewpoints. The Beckian view of psychotherapy, which is speaking only from research studies, is challenged by therapists from other orientations who point out that knowledge of human behaviour and change comes from many sources (e.g. philosophy, literature, spiritual traditions) and science is only of them; a scientific approach cannot answer all questions of importance about the human condition. In our experience, not every cognitive therapist would describe him- or herself as a 'strict Beckian' in the sense of being led only by research.

CT comes under the umbrella term cognitive behavioural therapy (CBT). CBT is not a single approach but made up of various ones such as rational emotive behaviour therapy (REBT; Ellis, 1994), problem-solving training (PST; Nezu et al., 2007), stress inoculation training (SIT; Meichenbaum, 1985), relapse prevention (RP; Marlatt and Donovan, 2005) and dialectical behaviour therapy (DBT; Linehan, 1993). Each approach differs in the varying emphasis it places on cognitive as compared to behavioural principles and interventions (Hollon and Beck, 2004; Craske, 2010). When the same intervention is used, different explanations for change are advanced (Craske, 2010), e.g. in exposure treatment, behaviour theory attributes change to clients' staying long and often enough in feared situations until habituation (anxiety diminishes) occurs while a cognitive perspective attributes change to testing clients' fearful thoughts (e.g. 'I'll go mad if I stay for too long in this shop') in order to provide direct disconfirmation of them – she did not go mad in the shop – thereby leading to a reduction in anxiety.

Beck's CT is the dominant CBT approach in the UK because of the substantial evidence base supporting its effectiveness and is recommended by the National Institute for Health and Clinical Excellence (NICE) as the first line treatment in the NHS for a wide range of psychological disorders (NICE, 2005). The wider dissemination of CT in the NHS is under way through the government funded Improving

Access to Psychological Therapies (IAPT) programme (Department of Health, 2007).

Theory

In this section, we focus on some of Beck and colleagues' conceptual contributions to increasing our understanding of psychopathology (disturbances in thought, feelings and behaviours) and its amelioration.

Information-Processing Model

The cognitive theory of psychopathology is based on an information-processing model 'which posits that during psychological distress a person's thinking becomes more rigid and distorted, judgements become overgeneralized and absolute, and the person's basic beliefs about the self, [others] and the world become fixed' (Weishaar, 1996: 188). In other words, when we become emotionally distressed our normal information-processing abilities tend to become faulty because we introduce a consistently negative bias into our thinking, thereby maintaining our problems. For example, a person who makes himself angry over not being invited to a party, denounces his friends as 'bastards and backstabbers' and declares he will 'get them back for humiliating me' fails to consider other reasons for not being invited (for example, he becomes aggressive when he has had too much to drink). Distorted thinking underlies all psychological disturbances (Ledley et al., 2005). These distortions usually stem from underlying dysfunctional beliefs that are activated during emotional distress, e.g. a person experiencing depression after the break-up of his relationship insists 'I'll always be alone' (fortune-telling) because he believes he is unattractive (core belief).

Common information-processing distortions or biases include:

- **All-or-nothing thinking:** Situations are viewed in either/or terms (e.g. 'Either you're a success or failure in life. There is no in-between').

- **Mind-reading:** You believe you can discern the thoughts of others without any accompanying evidence (e.g. 'She doesn't have to tell me – I know she thinks I'm an idiot').
- **Labelling:** Instead of labelling only the behaviour, you attach the label to yourself (e.g. 'I failed to get the job, so that makes me a failure').
- **Jumping to conclusions:** Drawing conclusions on the basis of inadequate information (e.g. 'My girlfriend didn't phone when she was supposed to, so she must be going off me').
- **Emotional reasoning:** Assuming that your feelings are facts (e.g. 'I feel a phoney for not being able to answer the question, so I must be one').

Teaching clients how to identify and change these cognitive distortions (or errors as they are sometimes called) facilitates the return of information-processing that is more flexible, accurate, evidence-based and relative (non-absolute) in its appraisal of events.[2]

Hierarchical Organization of Thinking

The cognitive model of emotional disorders advances three levels of thinking to be examined and modified.

1 Negative Automatic Thoughts (NATs)

These are thoughts that come rapidly, automatically and involuntarily to mind when a person is stressed or upset (Gilbert [2000] calls them 'pop-up thoughts') and seem plausible at the time. NATs can be triggered by external events (e.g. late for a meeting: 'They'll think badly of me. My opinion won't count. I'll lose their respect') and/or internal events (e.g. pounding heart: 'I'm having a heart attack. I'm going to die. Oh God!'). NATs are situation-specific and the easiest cognitions to gain access to by asking the 'cardinal question of cognitive therapy: What was just going through my mind?' (J. S. Beck, 1995: 10). NATs can also occur as images, such as a person seeing himself 'dying of embarrassment' if he makes a faux pas when he is the best man at his friend's wedding. The clinical focus at this level is twofold: what we think (specific NATs in specific situations) and how we think, i.e. ways of processing information which results in some of the cognitive

distortions listed above. Three general questions can be used in attempting to modify NATs (Dobson and Dobson, 2009):

1 What is the evidence for and against this thought?
2 What are the alternative ways to think in this situation?
3 What are the implications of thinking this way?

2 Underlying Assumptions/Rules

These are the often unarticulated assumptions that guide our everyday behaviour, set our standards and values, and establish our rules for living. A positive assumption might be 'If I work hard then I will be a success in life' and an accompanying negative assumption (the reverse side of the positive one) might be 'If I slacken in any way then I will be a failure'. Underlying assumptions are often identified by their 'if … then' or 'unless … then' construction (for example, 'Unless I'm respected by others I can never have self-respect'). Rules are often expressed in 'should' and 'must' statements ('I must never show any weaknesses'; 'I should always be there for my friends when they need me'). As long as the terms of these rules, standards and positive assumptions are met, individuals remain relatively stable and productive and thereby avoid activating the 'bottom line' (Fennell, 1997), i.e. negative core beliefs; however, these rules serve to maintain or reinforce negative core beliefs rather than change them. Underlying assumptions and rules apply across a range of situations. Assumptions and rules are also called intermediate beliefs (J. S. Beck, 1995) as they link NATs with core beliefs.

Beck et al. (1985) suggest that maladaptive assumptions often focus on three major issues: acceptance (e.g. 'I'm nothing unless I'm loved'); competence (e.g. 'I am what I accomplish'); and control (e.g. 'I can't ask for help'). As rules for living contain our values and standards, interventions here are based on discussing the usefulness of following rigidly certain rules and assumptions that do not reflect the complexities of life. For example, 'I must give a hundred percent at all times' does not allow for life's vicissitudes and triggers self-condemnation when the person falls below this standard.

3 Core Beliefs

These are the fundamental beliefs about ourselves (e.g. 'I'm weak'), others (e.g. 'People will walk all over me') and the world (e.g. 'It's harsh and uncaring') that help us to make sense of our life experiences. We usually have both positive (e.g. 'I'm great') and negative (e.g. 'I'm useless') core beliefs. Core beliefs are usually formed through early learning experiences and become instrumental in shaping our outlook. In emotional disturbance, absolute and global negative core beliefs are activated and then process information in a biased way that maintains the core belief and discredits or disconfirms any contradictory evidence. Core beliefs can also be recently acquired, such as by experiencing a traumatic incident, e.g. a person who has always seen herself as strong and resolute fails to 'bounce back' from a serious car accident and concludes that she is weak and pathetic. The terms 'core beliefs' and 'schemas' are sometimes seen as synonymous in CT but schemas are not just core beliefs.[3]

Once the disturbance has passed, negative core beliefs become deactivated or return to their latent state and a more positive outlook is re-established (clients with personality disorders may have their negative core beliefs activated most of the time, see Davidson, 2008). Judith Beck (2005) suggests that negative core beliefs about the self can be slotted into three broad categories of helplessness (e.g. 'I'm no good on my own'), unlovability (e.g. 'I'm undesirable') and worthlessness (e.g. 'I'm rubbish'). Once negative core beliefs are identified, alternative views of the self can be formulated that are balanced, realistic, flexible and compassionate, e.g. 'I'm reasonably likeable but not to everyone. If I am disliked I can accept this as part of the experience of life rather than blame myself for being bad or defective in some way. I want to learn to be self-accepting, not self-condemning, when things don't turn out in my favour.'

How do these three cognitive levels interact? For example, a negative core belief ('I'm unattractive') is activated when a client's positive assumption ('If a man is interested in me, then that proves I'm attractive') is undermined by rejection ('He's not interested in me, so that proves I must be unattractive'). Her mind is flooded with negative

automatic thoughts (NATs) such as 'Why did he dump me? I can't cope without him. I hate being on my own. He's probably laughing at me now with his new woman.' The usual treatment strategy in CT is to focus on tackling NATs to effect symptom-relief before moving on to modifying underlying assumptions and core beliefs to achieve longer-term change and thereby reduce the chances of a relapse (a return to the original problem). It is important to point out that not *every* client problem will have this three-level examination. Short-term CT may focus primarily on modifying NATS (and also helping indirectly to reactivate the client's existing positive core beliefs which are temporarily inactive); unhelpful assumptions and rules are pinpointed when problems are recurrent while core beliefs are likely to be the main therapeutic target when treating problems requiring longer-term therapy. Dobson and Dobson (2009) suggest that it is quite likely that negative core beliefs gradually change without directly modifying them if clients continue to think and act differently over the longer term.

Clients can be taught through guided discovery (see p. 9) to gain access to their problematic thinking, whether on the surface and/or at deeper levels, which underscores one of the basic assumptions of CT, namely, that people have 'the key to understanding and solving [their] psychological disturbance within the scope of [their] own awareness' (Beck, 1976: 3).

Reciprocal Interaction of Thoughts, Feelings, Behaviours, Physiology and Environment

Greenberger and Padesky (1995) suggest there are five aspects to a person's life experience: thoughts, moods, behaviours, physical reactions and environment (past and present). For example, a person who loses her job (environment) sees herself as a failure (thought), feels depressed (mood), withdraws from social activities (behaviour) and complains of lack of energy and tiredness (physical reaction). Any change in one of these aspects is capable of influencing the others in

an interactive cycle; for example, a behavioural activation programme involving a slow but steady return to social activities initiates changes in the other aspects. In CT, the usual 'way in' to start a client's understanding of this interactive process is by identifying his situation-specific NATs, e.g. 'Do you know what you were thinking in that situation that led you to feel so anxious and rush out of the room?' (see Figure 2.1 on p. 16).

Sometimes others in the client's environment (partner or other family members) may be encouraged to come into therapy if his problems are to be properly addressed. Cultural messages that have an adverse impact on the client's difficulties, such as 'size zero' thinking in the fashion industry (e.g. 'Thinness is everything'), will need to be discussed as these messages are bound up with the client's negative self-view.

Cognitive Content-Specificity

This proposes that each emotional disorder has its own typical cognitive content or theme. For example, devaluation or loss in depression; danger or threat in anxiety; unjustified intrusion in paranoia; transgression of one's rules in anger; moral lapse in guilt. This cognitive content specificity is linked to Beck's (1976) concept of the 'personal domain' (anything an individual finds important in his/her life). Some examples may help to explain this relationship:

- An individual who sees herself as a successful businesswoman becomes depressed when her company fails as she concludes that 'My life is my work, and without my work, I'm nothing'.
- An individual who prides himself on his sexual prowess becomes intensely anxious when he experiences erectile failure with his current girlfriend.
- An individual who enjoys peace and quiet in her life becomes enraged when her next-door neighbour plays his music too loudly.

How an individual responds emotionally to events 'depends on whether he perceives events as adding to, subtracting from, endangering,

or impinging upon his domain' (Beck, 1976: 56). In the above examples, the first person's domain has suffered subtraction, the second person's is endangered and the third person's is being impinged upon. Cognitive content specificity has been refined to pinpoint key themes in each of the anxiety disorders, such as an imminent physical catastrophe in panic (e.g. dying, going mad, passing out) or losing mental or behavioural control that results in harm to oneself or others in obsessive-compulsive disorder (e.g. violent thoughts will be acted upon if not suppressed) (Clark and Beck, 2010).
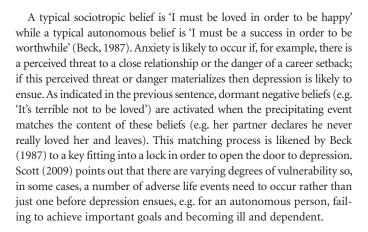
Cognitive profiles of each psychological disorder help to make interventions more precisely targeted, e.g. encouraging a client to exercise while he is feeling panicky, even though he wants to rest, in order to disconfirm his belief that his heart cannot take the strain. The specific 'cognitive architecture' of each disorder has led to the development of disorder-specific treatment protocols. What has emerged from this disorder-specific research are cognitive behavioural commonalities (e.g. distorted thinking, avoidance behaviours, rumination) across different psychological disorders which has prompted some researchers to discuss the usefulness of taking a transdiagnostic approach to treatment and research rather than a disorder-specific one (Harvey et al., 2004).

Cognitive Vulnerability to Psychological Disturbance

Vulnerability can be defined as an 'endogenous [internal], stable characteristic that remains latent until activated by a precipitating event' (Clark and Beck, 2010: 102). Beck (1987) proposed two personality types as vulnerability factors for developing depression or anxiety – sociotropy and autonomy:

> The autonomous individual gets his satisfaction from independence, freedom and personal achievement, while the sociotropic individual is dependent on social gratifications, such as affection, company and approval. (Blackburn and Davidson 1995: 29)

A typical sociotropic belief is 'I must be loved in order to be happy' while a typical autonomous belief is 'I must be a success in order to be worthwhile' (Beck, 1987). Anxiety is likely to occur if, for example, there is a perceived threat to a close relationship or the danger of a career setback; if this perceived threat or danger materializes then depression is likely to ensue. As indicated in the previous sentence, dormant negative beliefs (e.g. 'It's terrible not to be loved') are activated when the precipitating event matches the content of these beliefs (e.g. her partner declares he never really loved her and leaves). This matching process is likened by Beck (1987) to a key fitting into a lock in order to open the door to depression. Scott (2009) points out that there are varying degrees of vulnerability so, in some cases, a number of adverse life events need to occur rather than just one before depression ensues, e.g. for an autonomous person, failing to achieve important goals and becoming ill and dependent.

Continuum of Emotional Reactions

CT suggests there is a line of continuity between normal emotional and behavioural reactions to life events and excessive emotional and behavioural reactions found in psychopathology. As Weishaar and Beck explain (1986: 65):

> The cognitive content of syndromes (e.g. anxiety disorders, depression) have the same theme (danger or loss, respectively) as found in 'normal' experience, but cognitive distortions are more extreme and, consequently, so are affect [emotion] and behavior.

Also, physiological reactions (such as increased heart rate) would be similar if the perceived threat was psychosocial (making mistakes in front of others) or physical (being threatened in the street). Explaining to clients this continuum of cognitive–emotive–behavioural–physiological responses to life events can help them to reduce or remove the stigma they may associate with psychological distress thereby normalizing their experiences (Weishaar, 1993). The CT message is that no one is immune from experiencing psychological difficulties (therapists included).

Maintenance of Emotional Disorders

CT 'considers *current* cognitive functioning crucial to the maintenance and persistence of psychological disturbance' (Clark, 1995: 158; original italics). What is happening now is judged more important than what happened in the past for the following reasons (Westbrook et al., 2007):

(a) What might start a problem is not necessarily what keeps it going, e.g. being rejected several years ago is not the reason for the person's current isolation but her fear that if it happened again 'it will destroy me and therefore I'm not prepared to take the risk'.

(b) Gaining clear evidence of what is happening now in a person's life is usually easier to achieve than attempting to reconstruct past events – events that may be lost in the mists of time, e.g. collecting information across a range of current situations in order to pinpoint the client's key concerns rather than spending too much time trying to find an answer to his often-asked question, 'Why was I the only worrier in the family?'.

(c) Present maintaining factors can be altered whereas past factors cannot be because they lie in the unalterable past, but they can be better understood in terms of how the past continues to operate in the present, e.g. while her father might have favoured her older sister, the client still believes *today* that she is second best; so it is her current thinking about past events, not past events *per se*, that she needs to work on.

Exploration of the past is not neglected (see 'Here and Now Focus' on p. 10).

The Role of Behaviour

Behaviour plays a crucial role in maintaining emotional disorders as individuals act in ways that support or strengthen their dysfunctional beliefs. For example, in panic disorder, clients engage in safety-seeking behaviours which prevent (narrowly) their feared catastrophe from occurring (Salkovskis, 1991), such as holding on to something when feeling faint or avoiding exercise so as not to trigger a heart attack. Encouraging clients to drop their safety behaviours in feared situations helps them to gauge more accurately the true extent of the risks they

actually face. In CT, behavioural interventions are used in the service of cognitive change.

Practice

In this section, we look at some of the distinctive features of CT practice that provide the context within which clients are able to develop a cognitive understanding of their problems and the change methods required to tackle them.

Socialization

This means explaining to clients what the cognitive model is and how it will be used to tackle their problems. Equally important, their expected role in therapy is outlined to them along with the therapist's role. Clients' informed consent is needed in order for therapy to proceed. If socialization is overlooked, clients might understandably be bewildered by the therapist's questions and behaviour and prove more resistant to her clinical interventions than would normally be the case. Also, if clients have been in therapy, particularly non-directive approaches, then CT could come as a 'culture shock' if the way is not prepared through socialization.

Collaborative Empiricism

This term is used to describe the working style of therapy (Beck et al., 1979) where therapist and client join forces to tackle the latter's problems ('Two heads are better than one'). By collaborating, clients are actively engaged in the problem-solving process (this relationship is underpinned by warmth, trust, genuineness and empathy). 'Empiricism' focuses on reality-testing clients' thoughts and beliefs. Clients' cognitions are viewed as hypotheses rather than as facts; for example, a client who believes 'I'll never be happy again' following the end of a relationship is, from the CT viewpoint, making a bleak prediction based on her

current state of mind rather than stating an immutable and accurate view of her future.

Evidence collected from reality-testing (the client's mood begins to lift through renewed socializing) is evaluated to determine if it confirms or contradicts clients' hypotheses and 'by this means, clients are encouraged to view their thoughts as personal constructs [assumptions] of reality and to build their skills in evaluating their validity' (Nelson-Jones, 1995: 312). Through collaborative empiricism, clients learn to become personal scientists (or hypothesis testers). Working as co-investigators into problem-solving militates against the possibility of the relationship becoming one of 'guru' and 'devotee' and disabuses clients of the notion that the therapist's job is to 'fix me' while they remain passive in the 'fixing' process.

Openness

As CT practice is based on collaboration, therapy is open and explicit about 'what is going on', so the CT model is explained to clients and their permission is sought to apply it to their problems; the case conceptualization is shared with them. Therapists' mistakes are admitted and clients are encouraged to come up with solutions when therapy becomes stalled ('Just because I'm the therapist doesn't mean I have all the answers'). CT rejects any '"private" therapist models within the cognitive therapy paradigm, as this would sabotage the collaborative stance' (Blackburn and Twaddle, 1996: 9).

Agenda Setting

This is a business-like approach to therapy but it is not carried out in an impersonal way. Client and therapist agree in each session which topics are to be put on the agenda, and this device keeps both participants on track, thereby preventing or minimizing drift. Agenda setting militates against the client playing a passive role in therapy and makes efficient use of therapy time. The usual items placed on the agenda are: undertaking a mood check, including a review of the client's inventory

scores such as those of the Beck Depression Inventory (Beck et al., 1996); eliciting feedback from the previous session; reviewing homework; agreeing on topics for the current session; negotiating new homework; and asking for feedback about the session.

Problem-Focused and
Goal-Oriented

Clients are encouraged to list their problems in the first session and establish a goal for each one (problems are prioritized though the most troubling one may not always be tackled first). This teaches clients that an early problem-solving focus is sought rather than them using up valuable therapy time with rambling or long accounts of their current difficulties. Goals are stated in clear and specific terms so progress towards them can be measured rather than assumed (if clients are ambivalent about change then it is too early to introduce specific goals and discussion should focus on the client's concerns about change); it is important that goals are within the client's ability to achieve (e.g. wanting a partner back when there is no chance of her coming back). Setting goals fosters hope in the client that change is possible (Kinsella and Garland, 2008). Goals can change over the course of therapy as more information is obtained, problems change, or new ones emerge.

Guided Discovery and Socratic Questioning

Guided discovery is a process whereby the therapist acts as a guide to help clients uncover, examine and reality-test their maladaptive thoughts and beliefs; it aids the development of adaptive and balanced responses to these cognitions; and assists in the development of better problem-solving decisions. This guided discovery process is facilitated by Socratic method, derived from the Greek philosopher Socrates (c. 470–399 BC):

> If Socrates thought he could lead his interlocutors [those engaged in debate with him] to the truth by his questioning, it was because he

believed that the truth is already in us, albeit often unknown to us …
so when we learn the truth we are not really learning it, but remember-
ing what we once knew and have forgotten. (Kolakowski, 2008: 4–5)[4]

Cognitive therapists do not lead clients to the 'truth' but through
questioning help them to discover new perspectives that challenge
their maladaptive thoughts and beliefs; often these 'new' perspectives
are not so new, e.g. 'Discussing this problem with you has made me
realise that I already have the answers, so why aren't I doing some-
thing about it?' which prompts further self-discovery through Socratic
questioning – 'Do you know what stops you from doing something
about it?' Beck et al. (1993: 103) state that Socratic questions 'should
be phrased in such a way that they stimulate thought and increase
awareness, rather than requiring a correct answer'. For example,
'Could there be a pattern to this seemingly random behaviour and if
there is, what might it be?' in contrast to, 'This behaviour isn't random,
there's a pattern to it, isn't there?' (Client: Yes) 'What is it?' (Client: I don't
know). Examples of Socratic questioning may include (with an anxious
client):

'Do you know what thoughts or images were going through your mind
to make you feel intensely anxious about giving that presentation to
your colleagues?'
'Do you know what would be so terrible about not knowing the answer
to a question?'
'What would that mean to you if you couldn't answer it?'
'How would you like to cope if you couldn't answer a question instead of
"going to pieces"?'
'How would you like to see yourself if you stopped calling yourself
"incompetent"?'

Guided discovery through Socratic questioning is not about arguing
with clients, exposing their 'poor' thinking or telling them what to
think – they are unlikely to be convinced if the therapist just 'hands
them' an explanation for their worries. Helping clients to think things
through for themselves assists and accelerates their progress towards
becoming their own therapist.[5]

Socratic questions are not the only type of questions that cognitive therapists ask. Some examples: closed questions to focus the client's reply, 'Have you decided which problem to work on first?'; questions to confirm what the other person has said, 'So is the sticking point for you your manager's refusal to apologize?'; direct questions to gather assessment information, 'How many times this month have you been late for meetings?'; and leading questions to test the therapist's hypotheses, 'Would you say that you're more worried than excited about the promotion?' Do not persevere unnecessarily with Socratic questioning, which could turn into 'mental torture', if it becomes obvious that a client would clearly benefit from direct explanations of how to solve his problems. Once a potential solution has been offered, then the therapist can revert to a Socratic style by asking the client for his comments on the proposed solution.

Case Conceptualization

This refers to making sense of a client's problems within the cognitive model of emotional disorders (to what extent is the model compatible with the client's own view of the development and maintenance of her problems?). The conceptualization (also known as formulation) focuses on how the client's problems developed, current examples of when these problems are activated, and how these problems are being maintained (sometimes called, respectively, predisposing, precipitating and perpetuation processes). The maintaining factors are the main focus of the case conceptualization and the treatment plan that flows from it. Butler et al. (2008) advance three key principles that guide case conceptualization:

1   A conceptualization should be based on attempting to translate theory into practice (see first sentence).
2   A conceptualization should be hypothetical, i.e. both therapist and client are able to confirm, modify or discount the information used in developing one.
3   The conceptualization should be parsimonious (concise and clear). The more complex and long-winded the conceptualization, the harder it will be to remember and use for both therapist and client.

A recent addition to case conceptualization is listing clients' strengths (to balance their 'weaknesses') which can then be brought to bear in tackling their current difficulties: 'A primary purpose of case conceptualization is building client resilience' (Kuyken et al., 2009: 55). These authors suggest that for some clients case conceptualization is less likely to be overwhelming or distressing for them if the focus is as much on what is right with them as it is on their psychopathology.

Here-and-Now Focus

As discussed in the theory section, CT largely focuses on finding specific solutions to current problems. Exploration of the past only occurs when

> the patient expresses a strong predilection to do so; when work directed toward current problems produces little or no cognitive, behavioral, and emotional change; or when the therapist judges that it is important to understand how and when important dysfunctional ideas originated and how these ideas affect the patient today.
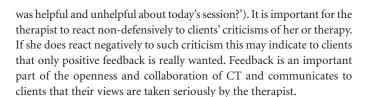> (J. S. Beck, 1995: 7)

However, continually looking backwards can convince the client that the solution to her problems lies in understanding her past instead of changing her present circumstances so that tomorrow can be better than today.[6]

Feedback

Feedback is obtained during the session and at the end of it. In-session feedback enables the therapist to ascertain if the points she has been making are understood by the client (for example, 'Can you put the thought–feeling link into your own words?') and correct any misunderstandings that may have arisen ('Thank you for the feedback, but cognitive therapy does not say that clients' problems are solely created in their heads. I might have explained it incorrectly. Let me try again'). End-of-session feedback asks the client to cast his eye over the session ('What

was helpful and unhelpful about today's session?'). It is important for the therapist to react non-defensively to clients' criticisms of her or therapy. If she does react negatively to such criticism this may indicate to clients that only positive feedback is really wanted. Feedback is an important part of the openness and collaboration of CT and communicates to clients that their views are taken seriously by the therapist.

Time-Limited

Due to its active, structured, collaborative and goal-directed stance, CT for uncomplicated cases of anxiety and depression usually requires between 4 and 14 sessions (J. S. Beck, 1995), while Wells (1997) suggests that a typical course of CT for anxiety is between 10 and 15 sessions. For chronic problems such as personality disorders, Davidson (2008) points to 9 months or longer for clinically important changes to occur.

Homework

If a client spends one hour per week in therapy, she needs to be encouraged to devote some of the remaining 167 hours to carrying out homework tasks. These tasks are carried out between the sessions based on what was done in the session. With cognitive therapy's emphasis on reality-testing, homework is the logical way of carrying out this function. Much of clients' competence and confidence in becoming their own therapist is derived from carrying out homework assignments. Burns suggests 'that compliance with self-help assignments may be the most important predictor of therapeutic success' (1989: 545). If some clients do not like the word 'homework', then the therapist can use alternatives such as 'real-life activities', 'between-session tasks', 'self-help assignments' or the client can use his own terms.

Becoming a Self-Therapist

The ultimate aim of CT is for clients to become their own therapist by using the cognitive model for present and future problem-solving. As

the client's problem-solving abilities increase, the therapist can become less active in guiding therapy and transfer more of the responsibility for directing it to her client. The transition from client to self-therapist can be matched by the therapist's transition from therapist to consultant or coach. Independence and self-reliance are explicit client goals in CT (Weishaar, 1993).

Dealing with Relapse

Instilling hope in clients that they can change is an important part of therapy; addressing the likelihood of relapse is perhaps equally as important (Dryden and Feltham, 1992). Because of this likelihood, it is wiser to use a term like 'relapse management' (Daley and Marlatt, 1997) instead of the usual 'relapse prevention', as the former term more accurately describes the post-therapy progress of fallible human beings (Neenan and Dryden, 2004). Clients can be taught that setbacks are likely to occur at some stage in their attempts to maintain change but these setbacks are only incidents in, not the whole story of, their progress. Additionally, setbacks can be seen as valuable learning opportunities, not signs of personal failure, which if constructively handled will put clients 'back on track'. In the closing sessions of therapy, clients summarize what valuable lessons they have learnt in CT, possible future difficulties that may trigger a relapse are pinpointed and coping strategies are rehearsed to deal with them. Booster sessions can be arranged to monitor clients' progress and focus on any problems they are finding hard to deal with. To reduce the chances of a relapse, clients need to practise their CT skills as a way of life (Beck et al., 1993).

Chapter Summary

The cognitive model of emotional disorders advances three levels of thinking to investigate (NATs, assumptions/rules and core beliefs) which are incorporated into a case conceptualization of the client's presenting problems. In this way, cognitive theory is linked to therapeutic practice.

Notes

1   Viktor Frankl, an eminent psychiatrist who survived Auschwitz, wrote:

> We who lived in the concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: the last of the human freedoms – to choose one's attitude in any given set of circumstances, to choose one's way. (1985: 86)

Despite the most appalling and inhuman conditions, a moral life was still possible for some inmates in the Nazi concentration camps and the Soviet gulag system rather than a collective descent into a dog-eat-dog struggle for survival (Todorov, 1999).

2   Gilbert (2000) objects to the word 'error' as it implies there is a correct way of thinking ('the client is wrong and the counsellor is right'). To sidestep this thorny issue, he suggests using non-contentious expressions such as 'anxious thoughts' or 'depressive thoughts' instead of 'cognitive errors'.

3   Technically speaking, 'Schemas are the cognitive structures [stored knowledge] that organize experience and behavior; beliefs and rules represent the content of the schemas and consequently determine the content of the thinking, affect [emotion] and behavior' (Beck, Freeman and Associates, 1990: 4). Others use the terms 'schemas' and 'core beliefs' interchangeably 'because the differences in meaning are relatively minor' (Dobson and Dobson, 2009: 152).

4   Not all philosophers speak favourably of the Socratic method. Blackburn (2001: 38) says that Socrates is 'infuriatingly fond of getting his stooges to say something, showing that they cannot defend it by articulate general principles, and concluding that they didn't really have any right to claim what they did … Socrates' procedure is only apt to give philosophers a bad name'. Socrates described himself as an 'intellectual midwife whose questioning delivers the thoughts of others into the light of day' (Gottlieb, 1997: 15).

5   Socratic questioning can give the impression that the therapist has an end-point in mind, such as to reveal a client's core belief about himself ('I'm no good'). Padesky (1993) argues that the best form of guided discovery assumes there are no preconceived answers or end-points. However, Wells explains:

> My own view … is that a combination of both knowing where to go, but allowing time to explore the patient's evidence for thoughts and for the patient to generate solutions is desirable. (1997: 56)

In our view, experienced clinicians usually have a good idea of the cognitive destination of Socratic enquiry but should remain open-minded that they could be, and sometimes undoubtedly are, wrong about a particular end-point.

6 In working with personality disorders, therapists spend more time on the client's developmental history and 'childhood experience tends to be more important since maladaptive schemas, established early in life, play a dominant role in many areas of functioning' (Weishaar, 1993: 74).