

ONE Cognitive Behaviour Therapies in Britain: The Historical Context and Present Situation

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The rise in the profile of cognitive behaviour therapy (CBT) is an international phenomenon, with theoretical and clinical contributions coming from across the European and anglophone world, but cognitive and behavioural interventions have a particularly significant – and sometimes controversial – position in contemporary Britain. Whilst the genealogy of many of the cognitive techniques used by current practitioners originates in the USA, there has been a strong tradition in evidence-based psychotherapeutic interventions on this side of the Atlantic. Much of the early impetus for the development of behaviour therapies originated with clinical psychologists and psychiatrists at the Maudsley Hospital from the 1950s onwards, and cognitive-behavioural interventions have become established practices across public sector fields, from the health services and social work through to education (Baistow, 2001). This chapter will chart some of the key moments in the development of cognitive behaviour therapies in Britain, from the first wave of behaviour therapies in the 1950s, through the second wave of the 1980s and 1990s associated with the 'cognitive revolution', and up to the recent third wave of approaches that draw from eclectic traditions. It will also explore the broader social and political aspects of the British context, in which CBT has become the dominant form of 'talking therapy' in the National Health Service (NHS), with significant political and economic backing.

The origins and professionalisation of behaviour therapies in Britain

Histories of CBT frequently cite Ellis and Beck as the original founders. While this is true of the cognitive component, a number of behavioural approaches were advanced by a group of clinical psychologists and psychiatrists at the Institute of Psychiatry and the Maudsley Hospital in

London, providing the foundations for an evidence-based therapeutic movement that underpinned the later development of cognitive-behavioural therapies.

The institutional setting of the newly amalgamated Bethlem and Maudsley Hospitals, forming a home for the University of London Institute of Psychiatry, provided a professional and experimental space for the development of psychotherapeutics in post-war Britain. Headed by Sir Aubrey Lewis, the imperative for critical experimentalism in research, along with a broad education in the philosophy of science, laid the foundations for a move away from traditional psychoanalytic approaches in Britain. This emergence of behavioural therapy as an experimental science at the Maudsley has been credited as one of the single most important developments in the international psychology community for facilitating the development of Behaviour Therapy as a distinct movement (Krasner, 1971). But how did this theoretical space emerge?

Shalomit Ramon argues that there was a rise in public interest, and sympathy, with those suffering from mental distress in after the Second World War, with a congruent rise in media coverage of the activities of psychiatrists (Ramon, 1985: 134). The inclusion of mental health services within the remit of the NHS had not been a given, and had not featured in early drafts of the implementation plans, until the integration of psychiatry into general medical services was guaranteed by Aneurin Bevan's insistence in 1944 (Busfield, 1998: 16).

The creation of state-funded hospital psychiatry resulted in a widening of hospital services for individuals suffering from distress categorised under the label of 'neuroses', who would previously have been treated by their family doctor and would not have been referred for secondary or tertiary care (Busfield, 1998: 16). The need for a training centre for the newly nationalised profession soon became apparent, which is how the Institute of Psychiatry originally came in to being, with research being essentially secondary to its role as a teaching hospital (Waddington, 1998: 188). For Keir Waddington, a significant outcome of the organisational structure of the Institute, split as it was over the Maudsley and Bethlem Royal Hospitals, was the ability to nurture a truly multidisciplinary approach to the treatment of mental distress, allowing the resources and scope for research across the full breadth of interventional techniques (Waddington, 1998: 188). Thus, both a department of psychiatry and a separate department of clinical psychology were established.

The institutional state of mental health services in the immediate post-war period was unfavourable to the recently professionalised clinical psychologist (Hall, 2007: 29), who was viewed primarily as a diagnostic assistant to the psychiatrist, operating within a traditional framework which regarded behavioural disorders within a medicalised disease model (Fishman and Franks, 1992: 166). Cyril Franks, a psychologist who trained at the Institute of Psychiatry, has argued retrospectively that the dissatisfactory status of the

psychological profession was one of the catalysts for the shift towards a new theoretical basis for psychotherapeutics (Fishman and Franks, 1992: 167). The development of behavioural psychology demanded a paradigm shift away from Cartesian dualism towards an acceptance of a more materialistic basis of psychological disorder – from treatment of the mind to treatment of the nervous system (Wolpe, 1963: 23). For Eysenck: ‘there is no neurosis underlying the symptom but merely the symptom itself. Get rid of the symptom and you have eliminated the neurosis’ (Eysenck, 1960). To quote Jan Ehrenwald’s broad summary:

Behaviour modification as a therapeutic tool is an offspring of a philosophy and a technique. The philosophy is frankly materialistic, positivistic, causal-reductive, and is based on Pavlovian, Watsonian, and Skinnerian principles of conditioned reflexes, operant reinforcement, and learning theory ... Behaviour is determined by genetic and environmental factors such as operant reinforcements, aversive or punitive interventions, and their consequences. The self – or the sense of self – is merely a product of our sociocultural environment generating self-knowledge and self-control. Freedom and dignity are illusions and autonomous man is a mythical animal. (Ehrenwald, 1991: 445)

A landmark publication for post-war behaviour psychology is Hans Eysenck’s 1952 paper ‘The effects of psychotherapy: An evaluation’, published in the *Journal of Consulting Psychology*. The study stemmed from Eysenck’s own criticism of a recommendation of the American Psychological Society that all trainee clinical psychologists should be schooled in psychoanalytic psychotherapy, employing an argument based on the ‘social need’ for psychotherapeutic skills. Looking to dispute this ‘social need’, Eysenck sought to question the efficacy of the psychoanalytic approach through an examination of data from various other studies, concluding that the evidence did not support the efficacy of therapy, to the extent that there actually appeared to be ‘an inverse correlation between recovery and psychotherapy; the more psychotherapy, the smaller the recovery rate’ (Eysenck, 1952). Jack Rachman, a PhD student of Eysenck who trained at the Maudsley, argued that patients treated with psychoanalysis were highly selected, based on the likelihood of their ‘suitability’ for treatment: specifically in terms of their level of education and social status (Eysenck, 1973). His primary piece of research was based on ‘spontaneous remission’, the phenomenon of patient recovery from depression or neurosis as a result of natural, non-interventional causes. When the statistics for spontaneous remission are analysed, he argued, it is difficult to make a case for the efficacy of psychoanalytic therapy beyond the normal base-level of recovery through spontaneous remission (Eysenck, 1997: 179).

This critical engagement with psychoanalysis can be seen as laying the foundations for the reconceptualisation of psychotherapeutics, and the growth of a behavioural approach arrived at through clinical experimentation. Isaac Marks’ thesis, later published as a Maudsley Monograph under the title

Patterns of Meaning in Psychiatric Patients (Marks, 1965), falls into this tradition, as a study whose initial object was to test psychoanalytic methods (Marks, 2009, personal communication). Marks offers the quip that 'we were Popperians before we even knew of Popper' (Marks, 2009, personal communication), referring to Karl Popper's *Conjectures and Refutations*, in which he argued that psychoanalysis was a pseudoscience as it was not falsifiable (Popper, 1963). Subsequently, the first 'behaviour therapy' paper is deemed to have been that published by the clinical psychologist H.S. Jones, from studies at the Maudsley in 1956, entitled 'The application of conditioning and learning techniques to the treatment of a psychiatric patient' (Jones, 1956).

While experimentation was being carried out in the psychology department of the Institute of Psychiatry, Aubrey Lewis was simultaneously encouraging members of the department of psychiatry to clinically evaluate the efficacy of the methods being carried out by the psychologists (Gelder, 1968: 111), which challenges Maarten Derksen's assertion that psychiatrists at the Institute of Psychiatry were ambivalent about the developments being made by the clinical psychologists (Derksen, 2001: 275). This analysis began with J.E. Cooper's small-scale control study of de-conditioning treatments published in the *Lancet* in 1963; 'A study of behaviour therapy in thirty psychiatric patients' (Cooper, 1963), and was soon followed by an extended collaborative study by Cooper with Isaac Marks and Michael Gelder (Cooper et al., 1965). This paper, along with further studies by Marks and Gelder, suggested that patients suffering from phobias responded more rapidly to desensitisation techniques than patients suffering from other neurotic disorders, and that desensitisation, along with psychotherapy, could offer a significant improvement in patients' symptoms across the anxiety disorders (Gelder et al. 1967).

It was not only the Maudsley Hospital that was involved in pioneering behaviour therapy techniques. Victor Meyer was simultaneously developing therapeutic interventions for obsessive-compulsive disorder (OCD) at the Middlesex Hospital, where he founded a Behavioural Psychotherapy Unit in 1962 (Bruch, 2002). Meyer developed exposure-and-response-prevention therapy (ERP) for patients suffering from OCD by exposing them to the stimuli that provoked their anxieties and preventing them from performing their anxiety-reducing rituals. For example, one of Meyer's first patients to undergo this treatment had a severe fear of dirt: she was gradually exposed to dirty objects whilst being denied access to water and cleaning agents over a period of eight weeks, and her anxiety and compulsive cleaning behaviour began to wane (Meyer, 1966). Stanley Rachman cites this research as a key turning point for psychotherapeutic practice:

What he did was very brave. Dr. Meyer applied to humans what studies had shown applied to frightened animals: if they were exposed to what scared them for a prolonged period of time and prevented from leaving the situation, they became less scared. Therapists were scared to do it with patients ... he had broken the ice. (Rachman, 2005)

Given the budget constraints of the post-war nationalised healthcare service, investment into the rates of efficacy of treatments in psychology and psychiatry can be seen in part as a rational consequence of the economics of healthcare. As a result of this shared interest in the evidence-base of psychotherapeutic treatments, clinical psychologists and psychiatrists working on behaviour therapies were able to make a strong case for the use of their approaches over others in the NHS, even at such an early stage in the service's development.

The coming of age of behaviour therapy as a professionally recognised field in the UK can be best dated as 1963, with the establishing of the journal *Behaviour Research and Therapy* (referred to by the acronym *BRAT*). In the absence of an association or society to represent the interests of the field, the founding of the journal fell to Hans Eysenck and Jack Rachman to initiate, which was essentially done by arranging a personal meeting with Robert Maxwell to persuade him to take up the cause and publish the journal under Pergamon Press (Eysenck, 1960: 149). The editorial to the first edition invited, among various types of study, 'experimental investigations (animal or human) of mechanisms involved in abnormal behaviour' (Eysenck, 1963: 1), illustrating the continuation of the position of earlier behaviourists that there was essentially no difference in the psychological mechanisms of animals and humans.

The first textbook for training in behaviour therapy in Britain was authored by Eysenck with S. Rachman in 1965, *The Causes and Cures of Neurosis: An Introduction to Modern Behaviour Therapy Based on Learning Theory and the Principles of Conditioning*. Victor Meyer and Edward Chesser established a formal training course in behaviour therapy at the Middlesex Hospital in the 1970s, which later became a higher degree diploma course in 1979 (Bruch, 2002). A further significant textbook for training, *Clinical Psychology: Theory and Therapy* was published by Dougal MacKay in 1975. MacKay, based at the University of Bristol, was not only a key figure in the 1970s and 1980s in terms of training a new generation of clinical psychologists and therapists, but also contributed to the development of behavioural therapies for a broad variety of disorders including sexual dysfunction, insomnia and assertion problems (Dryden, 1985: 113).

With the quantity of publications in the field rising, and the number of qualified practitioners in psychiatry and psychology increasing by the early 1970s, a professional association was founded in 1972 in the form of the then British Association for Behavioural Therapy (BABP), after a meeting of various interested delegates at the Middlesex Hospital in London (Lomas, 2008). The following year the association founded its own journal, initially the *BABP Bulletin*, later to become the journal *Behavioural Psychotherapy*. Four years later, the European Association for Behaviour Therapy (EABT) was officially founded, but there had already been an informal association between the BABP with its analogues in the Netherlands and Germany for several years (EABT, 2009).

At its conception, the membership of the BABP was spread across several professions, although it was still dominated by the traditional fields of psychiatry and psychology (Lomas, 2008): This situation was to change dramatically over the next 30 years as therapeutic treatments were deployed by a much wider range of practitioners in the NHS, particularly in primary care community mental health teams. From the early 1970s, efforts were made to expand the practise of behaviour therapy outwards, from the traditional professions to nursing staff. Isaac Marks identified a problem in the restriction of access to therapies, given that only a few hundred psychologists practised in the UK at the time. In order to widen the availability of behavioural treatments, a course was set up at the Maudsley to train nurse therapists. Marks chose nurses as a target group for pragmatic reasons: they constituted a large section of the NHS workforce across the country and there was no shortage in numbers. But he was also motivated through his experiences of working in developing countries with non-qualified practitioners who had limited training but were capable of performing required medical procedures effectively; borrowing from the Chinese term 'barefoot doctor', denoting rural farmers trained in basic paramedic procedures, Marks coined the term 'barefoot therapists' for the new generation of nurses qualifying at the Maudsley (Gournay, 2000: 370). The widening of behaviour therapy practices from the traditional professions must also be seen in the context of the rise of community mental healthcare since the 1950s, with the majority of patients suffering from mental illness now being treated as outpatients by community mental health teams, incorporating the nursing and social work professions (Busfield, 1998: 18).

By the beginning of the 1980s, therefore, behavioural therapy had become an established paradigm, with a high demand for the services, and a professionalised workforce. But it was still controversial, having gained adversaries within other forms of psychotherapy, and providing a target for the anti-psychiatry movement (Thomson, 2006: 274). Its identity as a coherent, scientifically and philosophically grounded approach began to wane, however, as therapists began to adapt their clinical practice to include techniques guided by different models.

BT, CT and CBT

CBT as it is practised now in Britain is by no means an unmediated product of the behaviour therapies developed at the Maudsley in the 1950s and 1960s. Approaches to psychotherapy underwent a so-called 'cognitive revolution' during the 1970s, drawing on therapeutic techniques developed in the USA.

The invention of the cognitive therapies is classically attributed to two psychotherapists: Albert Ellis and Aaron Beck. As therapist Meir Stolear

argues, the history of cognitive therapy has been heavily biased towards the Beckians, with Ellis having been somewhat marginalised (Stolear, 2009, personal communication). In response to this, and in consideration of the fact that Ellis' writings pre-dated Beck's, I will deal with Albert Ellis's theories first.

Ellis's rational-emotive therapy departs from the Eysenckian approach in quite a dramatic way, although it, too, was formulated through a negative response to Freudian psychoanalysis (Hoffmann, 1984). Ellis's first work on rational emotive behaviour therapy dates to 1955, when he first began to practice it after conducting a systematic review of available forms of psychotherapy (Ellis, 2007: 14). For Ellis, the personal story of the patient was crucial to understanding the formation of the neurosis – in direct contrast to Eysenck's dismissal of the patient's personal life as having any significance to his or her treatment (Ramon, 1985: 198). For Ellis, the psychoanalytic notion of suppression was flawed: instead of the effects of childhood being manifested through unconscious processes, rational-emotive therapy identified a conscious, active 'self-indoctrination' process, in which the patient reiterates pathogenic thoughts and inner-monologues borne out of childhood experiences (Ellis, 1962). Similarities are present in Beck's cognitive model of depression, which explicitly draws upon Ellis's work and dates to 1976 (Beck, 1976/1991: 240). Both have since agreed that the fundamentals behind their theories of emotional disorder are largely similar, with only a few 'differences in technique and style' (Beck and Ellis, 2000). Aaron T. Beck's most widely read book *Cognitive Therapy and the Emotional Disorders* was first published in 1976 and provides a step-by-step targeted approach to the specific problem areas associated with depression. These techniques primarily involve deconstructing and challenging the client's 'maladaptive' beliefs (Beck, 1976/1991). The therapist's primary role, then, is to explore how the client's belief system came to be so, and gradually pull these beliefs apart, providing alternative, more positive ways of thinking, which are then reinforced through 'cognitive rehearsal'. This latter technique – the role-playing of difficult situations and preparing a positive reaction, then rewarding oneself for accomplishing the positive reaction when the situation actually arises – does have similarities with behavioural conditioning, but the explicit exploration of the origins of the emotional disorders as *a fundamental part of the therapeutic process itself* is at odds with the approaches of more traditional behaviour therapies.

At first glance, it appears difficult to see how the behavioural and cognitive world-views could be compatible – the former, after all, frequently rejects the relevance of the latter in the aetiology of psychopathology. As G. Terence Wilson states, in traditional behaviour therapy 'cognitive approaches are rejected as improper targets of experimental study or relegated to the status of epiphenomenal events that are merely the by-products of physical actions in the body and/or the external environment; they exert no causal effect on a person's behaviour or subjective state' (Wilson, 1978: 8). Further

incompatibilities are apparent in the interest of cognitive psychologists in how experience becomes organised and structured by the mind, whereas traditional behavioural psychologists rejected the possibility of the mind possessing innate organisational ability (Schulz and Schulz, 2004: 492). The most significant disparity between the two theoretical systems is perhaps their view of volition: for behaviourists, free will is purely epiphenomenal, whereas cognitive psychology allows for volition and ascribes volition agency in particular cognitive processes, such as the selection of experiences to commit to memory (Schulz and Schulz, 2004: 493). However, therapeutic integration *did* occur, and it has indeed been argued that the cognitive revolution came about as a development within behavioural therapy, or was to some extent 'implicitly' influenced by it (Hoffmann, 1984: 5).

The extent to which cognitive processes could be completely excluded from explaining the efficacy of behavioural therapy was doubtful – the effect of the patient's expectation of positive results, for example, is a cognitive process *as distinct from* a behavioural one (Hoffmann, 1984: 5). Therapeutic strategies such as verbal conditioning, as developed by Luria (1961) and Staats (1963), and subsequently taken up in Britain by Michael Gelder (1965), are particularly similar to a cognitive approach, to the extent that it seems peculiar to categorise it as a solely behavioural intervention (Eifert, 1987: 176). Self-instruction techniques, in which 'clients are taught to emit self-statements that are incompatible with, and opposite in emotional content to, the negative self-statements they have employed previously' (Eifert, 1987: 176), had marked similarities to the semantic reinforcement techniques in Beck's cognitive therapy for emotional disorders (Beck, 1976/1991).

The boundaries between the categories of cognitive and behavioural interventions are evidently unclear, yet the incorporation of cognitive models remained highly contentious for many self-professed behavioural therapists. From a practical perspective, Hoffmann argues persuasively that the integration of cognitive and behavioural techniques was in part a result of consideration of time and economics: *in-vivo* treatment of neuroses was a long and costly process whereas simulation thereof, through use of symbolic stimuli and through verbally-induced 'cognitive rehearsal', can reduce the time required for treatment to take effect (Hoffmann, 1984: 5).

A key text that brought together behavioural and cognitive approaches was Albert Bandura's work on self-efficacy which dealt with the cognitive aspects of fear alleviation and their impact upon the patients' behaviour modification – challenging the traditional behavioural models of the treatment of phobia (Bandura, 1977). It is important to reiterate that this development, as with most of the significant texts which contributed towards the cognitive shift in psychotherapy, came about through the clinical observations by therapists of their patients, rather than a 'trickle down' diffusion of applied methods from the theoretical developments in cognitive science.

In terms of charting the rise of the integrated 'cognitive behavioural' approach in psychotherapy, it would be worthwhile to take a nomological approach, identifying instances of the term in the literature to create a historical map of the growth of CBT. According to David Clark and Christopher Fairburn, 'cognitive behaviour therapy can be found [although they state this without reference] in the first instance in the literature of the mid 1970s, with the first clinical trials coming at the end of the same decade' (Clark and Fairburn, 1997: ix). This is a roughly accurate pronouncement: an inaugural conference on CBT was held in New York in 1976 (Wilson, 1978: 7), with Mahoney's *Cognition and Behaviour Modification* appearing in 1974. A 1978 book, published in the USA and edited by Foreyt and Rathjen, includes the rather amusingly titled introduction: 'Cognitive behaviour therapy: Paradigm shift or passing phase?' (Wilson, 1978). Arguably, the first serious 'cognitive behaviour' text came as far back as 1969 with A. Bandura's *Principles of Behaviour Modification*, which argued that certain therapeutic processes, such as covert modelling, were better conceived of as cognitive processes rather than behavioural conditioning (Bandura, 1969).

Philip C. Kendall and Steven D. Hollon, in the introduction to their 1979 *Cognitive-Behavioural Interventions: Theory, Research and Procedures*, emphasise that CBT 'is not yet another new exotic therapy. Rather it is a purposeful attempt to preserve the demonstrated efficiencies of behaviour modification within a less doctrinaire context and to incorporate the cognitive activities of the client in the efforts to produce therapeutic change.' (Kendall and Hollon, 1979: 1). The same authors argue that the 'hyphenation' of the two terms came about through bilateral movements, as behaviour therapists turned their research to mediation techniques (such as symbolic stimuli, as discussed above), and a certain degree of interest shown by cognitive therapists towards the more established field of behaviour modification (Kendall and Hollon, 1979: 2).

In terms of institutional integration in Britain, the key turning point didn't occur until the 1990s, when the alliance of the cognitive and the behavioural approaches became institutionally recognised through the renaming of the BABP to the British Association of Behavioural and Cognitive Psychotherapies in 1992. In the same year the authors of the *Handbook of Psychotherapy and Behaviour Change* documented that:

Most of the people who used to consider themselves behavioural therapists now identify themselves as cognitive-behavioural. Also, most people who once considered themselves strictly cognitive practitioners are now willing to take on the cognitive-behavioural label as well. Although many influences have produced these changes, it is pleasing to note that the effect of the research has been substantial. (Bergin and Garfield, 1994: 824)

The following year, the second edition of *Behaviour Modification*, a handbook of behavioural therapy interventions which was aimed primarily at

social workers and originally published in 1982, was issued under the new title *Cognitive Behaviour Therapy: Research, Practice and Philosophy*. The author, Brian Sheldon, argued that it was only with moderate enthusiasm that the addition of the cognitive framework to more traditional behavioural techniques had been adopted in social work, but that positive outcomes in effectiveness research, particularly for probation, had led to a shift in practice: 'this is a difficult field and we need all the help we can get' (Sheldon, 1995: xiii).

It is perhaps no accident that the integration of the cognitive and behavioural approaches became dominant during the 1980s and throughout the 1990s, as there was a concurrent movement for the integration of therapies. This was not by any means an attempt to create 'grand unified theory' of mental illness and therapy, but rather as an acceptance of the value of the diversity of approaches to psychotherapy and a positive attitude towards pluralism. Indeed, this was a period in which interdisciplinarity became common across the academic social sciences. This development within psychotherapy occurred primarily in the USA, as an attempt to develop a 'rapprochement' between the competing approaches to psychotherapy, but had an influence across the anglophone world, and a movement for integrative psychotherapy has gained considerable popularity in the UK (Dryden, 1992; Evans and Gilbert, 2005; Norcross and Goldfried, 2005).

CBT Research and Training in the UK

As mentioned above, the Maudsley Hospital and Middlesex Hospital pioneered early research and training in behaviour therapy, but Michael Gelder's move to Oxford led to a further research group being founded at the University of Oxford's Department of Psychiatry in 1970, initially specialising in research on agoraphobia and depression. In later years, with the addition of David Clark, Paul Salkovskis and Anke Ehlers to the centre's staff, research expanded to the application of CBT approaches to post-traumatic stress disorder, the anxiety disorders, hypochondriasis and obsessive compulsive disorder (Gelder and Mayou, 1997: 328). After the retirement of Professor Isaac Marks from the Institute of Psychiatry at King's College London, Salkovskis and Clark were appointed as professors of clinical psychology at the Institute of Psychiatry, acting as clinical directors of the Centre for Anxiety Disorders and Trauma at the Maudsley Hospital. This move re-established the Institute of Psychiatry as one of the primary centres for CBT, with Anke Ehlers following in 2005 to act as the Centre's research director.

A further school for CBT training and research is that centred around Windy Dryden at Goldsmiths, University of London, which specialises in rational emotive behaviour therapy. Dryden has been a particularly

significant figure for updating and popularising Ellis's REBT approach for a British audience, and was part of the 'second wave' of CBT theorists, influenced by cognitive therapy techniques which came to the fore on the cusp of the 1970s and 1980s. Following substantial training and co-therapy practice with Ellis in the late 1970s, and a six-month sabbatical with Aaron Beck in 1981, Dryden went on to start one of the first ever CBT training programmes at Aston University in 1982–83. This later expanded to become the basis of a Diploma in Cognitive Approaches to Counselling and Psychotherapy at Goldsmiths, University of London in 1988, and later an MSc programme in rational-emotive and cognitive-behaviour therapy in 1995. Dryden is also the patron of the Association for Rational Emotive Behaviour Therapy (AREBT) (Dryden, 2010, personal correspondence). The AREBT is an important professional association, founded in 1993 by counsellors and REBT practitioners. The Association publishes a professional journal, *The Rational Emotive Behaviour Therapist*, as well as co-ordinating conferences and workshops, and has developed a comprehensive accreditation pathway for training therapists. In addition, the AREBT played a joint role with the BABCP in setting up the CBT Register UK, providing a public-access database of accredited CBT and REBT therapists (AREBT, 2010).

The Centre for Rational Emotive Behaviour Therapy, based at the University of Birmingham, also provides primary and advanced certificate training in REBT, along with peer supervision. The Centre was founded by Peter Trower and Jason Jones, based on the same model as the Albert Ellis Institute, New York, which accredits its courses (Centre for Rational Emotive Behaviour Therapy, 2011).

Other significant centres for CBT in the UK include the University of Exeter's Mood Disorders Centre, led by Professor David Richards. The Exeter group focuses upon major depressive disorder and bipolar disorder, taking a transdiagnostic approach to understanding the relationship between these and their co-occurring psychiatric disorders and physical health problems (Mood Disorders Centre, 2010). The University of Edinburgh's Health in Social Sciences department offers clinical training, with Kenneth Laidlaw's research being quite unique in its specialisation on CBT with older people (Laidlaw et al., 2003). Paul Salkovskis' move to the Department of Psychology at the University of Bath in September 2010 signals the beginning of a further centre for training and research in CBT.

While there are currently 37 universities providing training courses in cognitive and behavioural approaches to counselling and psychotherapy (BABCP, 2010), training is by no means restricted to university departments. The Association for Psychological Therapies provides training to the NHS and social services in CBT for specific disorders, as well as a number of 'new wave' approaches, such as schema-focused therapy and acceptance and commitment therapy, employing clinical psychologists as course leaders on a consultancy basis. The Centre for Stress Management, directed by Professor Stephen Palmer, has also offered accredited training

since its foundation in 1987, with diplomas and advanced certificates in both CBT and REBT in association with the Centre for Cognitive Behaviour Therapy and the UK Centre for Rational Emotive Behaviour Therapy. Among the most popular and long-running training workshops are those of Christine Padesky, co-author of the bestselling self-help book *Mind Over Mood* (Greenberger and Padesky, 1995).

Self-help material such as *Mind Over Mood* plays a key role in CBT in the UK, particularly in the low-intensity interventions associated with IAPT and the NHS Books on Prescription scheme. A significant figure in the early development and popularisation of self-help material was Robert Sharpe, whose book *Self Help for Your Anxiety: The Proven 'Anxiety Antidote' Method* was published in 1979 (Sharpe, 1979). Sharpe also made a series of CBT-based self-help television programmes for ITV under the title 'Lifeskills', dealing with issues such as stress, agoraphobia, assertiveness and relaxation techniques (Sharpe, 2010). In more recent years, the *Overcoming ...* series of self-help books has perhaps been one of the most important in enabling access to CBT to a wide audience, covering over 30 different conditions (Overcoming Ltd, 2010).

CBT in Practice: Mental Health Policy, IAPT and Community Settings

Writing in the early 21st century, it has been evident for at least 20 years that, although still controversial, CBT has become the most dominant form of therapy, and recent policy developments have rendered it by far the most dominant form of psychotherapy now available through the NHS. The advent of the Labour Government's Increasing Access to Psychological Therapies scheme in 2007 is one of several policy attempts to improve mental health services, and one which has been continued by the Coalition Government (HM Treasury, 2010).

One avenue of explanation that must be explored in this context is the rise of evidence-based medicine in British healthcare, followed shortly after by a growth in evidence-based psychology. The term was coined in the early 1990s; according to the MEDLINE database of international publications in the life sciences, collated by the US National Library of Medicine, the term was cited only once in 1992, rising to 2,957 citations by February 2000 (Straus and McAlister, 2000: 837). Those lobbying for an increase in funding for CBT services readily engaged with the evidence-base agenda. David Clark, along with many other academic psychologists, and specifically those who speak in favour of CBT in policy, underline its evidence base as demonstrated through randomised control trials, review articles and meta-analyses. This is by no means a new trend in clinical psychology, as the early behaviour therapy control trials at the Maudsley illustrate (Buchanan, 2010).

In England and Wales, evidence-based practice became institutionalised with the foundation of the National Institute for Health and Clinical Excellence (NICE) in 1999, which provides guidelines to NHS practitioners for best clinical practice and evaluates the cost-benefits of particular treatments within the framework of a state-funded healthcare system (Dobson, 1999). The NICE Guidelines on Depression and Anxiety, published in December 2004, advised that 'When considering individual psychological treatments for moderate, severe and treatment-resistant depression, the treatment of choice is CBT' (National Collaborating Centre for Mental Health, 2004).

Evidence-based medicine is not without its cogent critiques, however, particularly in psychiatry. Concerns have been raised that published evidence is skewed towards positive outcomes because negative results tend not to be published. This problem, referred to as 'publication bias', is a long-term feature of publishing in science and medicine. It occurs when a journal with a particular editorial agenda in favour of a treatment reject negative results for publication, and in terms of authorial selection as to which studies are or are not included in meta-analyses, resulting in negative results not being included in studies, biasing overall statistical results towards the agenda of the author (Begg and Berlin, 1988). Pim Cuijpers has argued that the efficacy of psychotherapies, CBT included, is 'considerably overestimated' in the treatment of depression in adults as a consequence of publication bias in meta-analyses (Cuijpers, 2010: 178).

Even representatives of the CBT community itself have demonstrated reservations about the effects of the guidelines on effective practice. Paul Salkovskis, editor of *Behavioural and Cognitive Psychotherapy*, published an article criticising NICE's guidelines, arguing that their explicit focus on the randomised control trial as the fundamental knowledge base for governance did not reflect the true developmental process which had underpinned CBT. He argued that the implementation of the guidelines would lead to a narrowing of the scope of CBT in practice, which would counteract the productive developments gained through the pluralist, integrative approach developed in the 1990s (Salkovskis, 2002).

Despite the recommendations contained within the NICE guidelines, it took at least three years for the cause to be taken up by politicians, and then only as a result of considerable lobbying. The key figure for initiating this process was the Labour peer, Lord Richard Layard of Highgate. An economist and director of the LSE's Centre for Economic Performance, Layard had been the primary policy architect of the New Deal under the Labour Government after 1997. His motivations for improving access to psychotherapies were, in part, in keeping with the wider project of the New Deal, as it recognised the detriment caused to the national economy by incapacity through mental distress. Layard has a longer-standing interest in mental health, related to his interests in the economics of subjective wellbeing (Layard, 2009, personal correspondence). This is illustrative of a wider

intellectual shift towards a concern with the subjective in the late 20th century, growing out of the overall problematic of the disparity between increased economic wealth and the incongruous lack of growth in individuals' happiness in Western society. Layard's book, *Happiness: Lessons from a New Science*, is a popular exemplar of such concerns; combined with a simplified explication of recent neurobiological sciences demonstrating the 'reality' of subjective emotion through use of imaging technologies which demonstrate positive and negative affect in brain function (Layard, 2005).

Concerted efforts to implement the NICE guidelines began with Layard's success in getting a pledge to improve care for mental illness included in the Labour Party Manifesto for the 2005 general election – in which, through accident, the pledge was to improve 'behavioural, as well as drug therapies' (Labour Party, 2005), neglecting to include the 'cognitive' aspect. Layard was advised that expert confirmation of the evidence base for the efficacy of psychotherapeutics would be required in order to persuade policy-makers of the importance of investment. Consequently, David Clark, Professor of Psychology at the Institute of Psychiatry, was called in to conduct a question-and-answer session. Clark has continued to play a key role in authoring policy documents and acting as a national adviser to the Improving Access to Psychological Therapies (IAPT) initiative (Layard, 2009, personal communication).

The implementation of IAPT, with the institution of less orthodox forms of low-intensity therapy, has raised concerns among therapists at the level of competency with which they will be carried out, representing a concern with the de-professionalisation of psychotherapy delivery. With the concurrent growth in the number of therapists in the NHS as a result of IAPT, with 3,600 therapists being required to implement to policy, there has been a corresponding development towards regulation of the practice (Laurance, 2009). Draft standards of proficiency were released by the Health Professionals' Council in 2009 (HPC, 2009). Responses from the psychotherapy community displayed dissatisfaction with the medical model of regulation; with the client seen as a 'passive object who receives treatments and procedures' (Association of Independent Psychotherapists et al., 2009). Further criticisms have been levelled by the British Association of Psychotherapists (BAP) who state that:

Many if not most practitioners see their work as more an art than a science. Any attempt to impose a quasi-objective framework of standards and competencies not only stifles creativity but also damages therapeutic work with the client. Applying a predetermined set of external principles means overriding the client's individuality. This is ethically unacceptable as well as therapeutically ineffective. (Laurance, 2009)

The integration of psychotherapy into an NHS framework has raised particular tensions with regard to the imposition of a medical model of governance

that practitioners see as misplaced. This is echoed again in Salkovskis's critique of evidence-based medicine as a means of selecting treatments:

Evidence Based Medicine may be appropriate as a way of making coherent sense of dozens of studies in which thousands of patients are administered identifiable doses of medication, or in treatments such as most psychotropic medications, which have been stumbled upon rather than developed and refined. It seems unlikely that it will ever be appropriate to exclusively consider the management of psychosocial problems in this way; to do so would be to endorse a one-dimensional approach to science. CBT has thrived because, from the earliest days, it has been both evidence based and empirically grounded. This grounding is in a range of different types of evidence, including but definitely not confined to randomised controlled trials. (Salkovskis, 2002)

The professionalisation of CBT has perhaps reached an apex, but increasing integration into the healthcare system has led to a perceived challenge to the therapy profession, with low-intensity practitioners with short-term training covering part of the workload that would previously have been the remit of therapists. It has also led to questions as to where the profession should stand within the NHS: as fully integrated into medicine or as a practice with separate modes of clinical governance and regulation.

While access to CBT in the NHS has courted the most media attention, the health services are not the only area of public service in which CBT-based interventions play a key role. Techniques are now widely used within social work, criminal justice and education. Within the criminal justice system there has been substantial investment in the use of cognitive behavioural techniques in rehabilitation programmes. These are a key feature in the rehabilitation programmes of young offenders, with training aimed at reducing substance misuse, drink-driving, violence and sexual offending (Sheldon and MacDonald, 2008: 269). Such programmes were originally developed by Canadian criminal psychologist Robert Ross in the 1980s, based on the theory that offenders experience 'cognitive deficit', tending towards concrete thinking rather than abstract, egocentricity, impulsiveness and lack of empathy. If offenders could be taught the necessary 'cognitive skills' they were lacking by means of creative problem solving, non-aggressive assertiveness training, role playing and social perspective training, their offending behaviour should consequently be reduced (Hawkins, 1996: 119). A number of trial programmes were carried out in the UK between 1992 and 1998, with Home Office evaluations carried out in 2002 and 2003. Two of the three studies found the programmes reduced reconviction rates, with one showing a marked reduction of reoffending among adult male sexual offenders (House of Commons Home Affairs Committee, 2005: 228–9). In the last decade a proliferation of cognitive behaviour programmes have been introduced in both custodial and community contexts, and such approaches have become an integral part of offender rehabilitation in the British criminal justice system (Robinson and Crow, 2009).

The social work profession has adopted cognitive behavioural approaches across several areas of practice, including parenting programmes in family services, substance abuse and harm reduction, anger-management training and social care of children. The latter in particular has not been without controversy, after the 'pindown' scandal in the 1980s in which children in residential care in Staffordshire were physically restrained for long periods of time, with the perpetrators justifying their actions as a form of behaviour training (Levy and Kahan, 1991). This example is one used in the training of contemporary social workers to reflect upon the ethical aspects of cognitive and behavioural interventions in their work, encouraging students to reflect upon the boundaries between intervention and coercion with vulnerable service users, particularly in relation to 'punishment' and 'reward' techniques (Wilson et al., 2008: 358).

Karen Baistow has described the rise in behaviour modification approaches in primary and secondary education. Before 1980 such techniques had been widely adopted in special schools, but increasing political attention to the effectiveness of school in the 1980s led behavioural approaches to become normal practice in mainstream education, particularly given the perceived increase in problems of discipline and pupil disruption. As well as 'classroom management' techniques, teachers were encouraged to increasingly use positive reinforcement strategies both to modify behaviour and to raise self-esteem (Baistow, 2001: 325). Baistow goes on to argue that the extension of cognitive and behavioural techniques into the wider community context has been surrounded by a political discourse of 'empowerment' and 'self-management' that has made it popular with both New Labour and the New Right (Baistow, 2001: 327). This aspect of CBT has been the focus of much controversy (House and Loewenthal, 2008), with some critics going so far as to claim that it is essentially government-sponsored 'personal spin doctoring' (James, 2007).

The 'Third Wave' Therapies

Despite the concerns raised by the consequences of IAPT for the profession and the very public criticisms of the philosophical and political thinking underpinning the practice of CBT, the actual range of cognitive behavioural approaches to psychotherapy and counselling in practice remains diverse and draws upon a broad range of theoretical frameworks.

Many new and eclectic approaches have been established through engagement with techniques from other schools of psychotherapy, drawing from a variety of philosophical perspectives. Other approaches, such as meta-cognitive therapy (MCT), have been developed in response to the

limitations of traditional cognitive therapy with particular client groups. MCT departs from the Beckian focus on the *content* of cognitions, and looks instead at the pathological effects of thought *processes* and *styles* of thinking (Fisher and Wells, 2009: 5). In addition, some long-standing CBT approaches have been updated for contemporary clinical practice. Behavioural activation, which focuses on mood improvement through increasing client engagement in pleasurable activities, has been a behaviour therapy technique since the 1970s (Lewinsohn and Graf, 1973). It was revived and further expanded in the early 2000s by Hopko and Lejuez, who also blended the approach with more recent concepts such as mindfulness-based therapies (Hopko et al., 2003).

More recent therapies have included interventions that have been developed with specific conditions or groups in mind. Dialectical behaviour therapy (DBT), for example, provides a framework of techniques and skills training primarily directed towards individuals suffering from chronic suicidal thoughts, and has a strong evidence base for clients with a diagnosis of borderline personality disorder (Dimeff et al., 2007: 1). Schema therapy, which also draws on Gestalt, psychoanalytic and constructivist schools, focuses on treatments for clients with chronic issues, such as the personality disorders, which do not respond well to more traditional CBT techniques (Young et al., 2003: 1–2). Similarly, the limitations of available approaches to treating eating disorders through CBT led to the development of the 'transdiagnostic approach'. This model, associated with Christopher Fairburn, focuses upon the behaviours and cognitions which tend to be common across the individual diagnostic categories of the eating disorders, paying attention to the common psychopathological beliefs and how these cognitions are maintained (Waller et al., 2007: 7).

Individuals with emotional difficulties associated with self-criticism and shame, many of whom may have suffered abuse or neglect, are the primary focus of compassion-based therapies. Compassion-focused techniques seek to activate experiences of safety, reassurance and self-compassion that, in turn, help to 'counter' maladaptive self-criticism (Gilbert, 2009: 211). As well as being significant for putting a strong emphasis upon the therapeutic relationship above and beyond the efficacy of the techniques in themselves, the theoretical foundations that underpin compassion-based therapy is notable for its basis in the cognitive neurosciences. This approach was developed in response to research in neuroscience that suggested that

there are in fact different affect processing systems that provide information on threat and safeness. It is possible, therefore, that people can experience affective arousal in threat systems (based on fast threat processing) but lack accessibility to affect systems that process information in terms of safeness and help regulate threat. (Gilbert, 2009: 205–206)

This is indicative of an emerging trend in CBT research, in which evidence from the neurosciences is beginning to inform the development of, as well as serve as a justification for, new therapeutic methods. A further example of this trend is eye movement desensitization and reprocessing (EMDR), which is used as a treatment for post traumatic stress disorder (PTSD). While this was initially discovered by a chance experience on the part of Francine Shapiro, she has since developed it in clinical practice with reference to 'neuro-network' concepts and the working model of 'adaptive information processing' (Shapiro, 2001: 29).

Neuroscientific concepts are not the only theoretical frameworks to guide new techniques, however. The rise of constructivist and post-modernist perspectives in recent years have seen an alternative strand within the 'third wave' of cognitive behavioural approaches. Some of these, such as acceptance and commitment therapy (ACT) and mindfulness-based CBT are characterised by a shift away from an emphasis of first-order change and didactic approaches, towards more contextual and experiential change strategies (Hayes, 2004: 6). Mindfulness-based therapies refer to a broad base of techniques influenced by the Buddhist philosophical tradition, enabling clients to 'pay attention in the present moment to whatever arises internally or externally, without becoming entangled or 'hooked' by judging or wishing things were otherwise' (Roemer and Orsillo, 2009: 2). The associated acceptance and commitment therapy also correlates with the Eastern philosophical tradition in that it takes as a foundation the acceptance of suffering as part of the normal human condition. ACT advocates actively challenge the binary notions of health/illness and normal/pathological, arguing that the mainstream mental health community has wrongly adopted these categories from medical models (Hayes et al., 1999: 4). It also draws from assumptions associated with the linguistic turn, seeing language as a tool for therapeutic intervention precisely because it can itself be at the core of psychological distress (Hayes and Strosahl, 2004: 4). A similar constructivist epistemology is present in the narrative therapy approaches of Michael White and David Epstein, focusing upon client's personal histories as a basis for therapeutic interventions (Payne, 2006: 8). While narrative therapy has broad-based theoretical origins, it has become adopted as an approach for cognitive behavioural therapists, particularly for use with clients experiencing psychosis (Rhodes and Jakes, 2009).

Cognitive behavioural approaches to therapy and counselling certainly remain eclectic. Recent years have seen CBT practitioners embracing theoretical approaches from across different schools of psychology, providing a wide range of techniques for clients experiencing a broad range of emotional difficulties, across the spectrum of psychiatric disorders. These approaches have become valued techniques not only in the psychology and healthcare communities, but are increasingly used also across the fields of social work, education and criminal justice. The chapters in this book further demonstrate

the breadth and depth of approaches available, and provide an opportunity to reflect on the present and future state of CBT in the British context.

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