

Skills *in*
COGNITIVE
BEHAVIOUR
THERAPY

1

PRACTISING CBT SKILLS WITHIN THEIR KNOWLEDGE BASE

On matters of style, swim with the current, on matters of principle, stand like a rock.
(Thomas Jefferson)

All people offering psychological help to their clients aim to do so in as skilful a way as possible. This book proceeds from the assumption that the concepts and methods of CBT can greatly help in achieving this aim, and its final chapter will suggest ways that practitioners can develop a self-efficacious approach to CBT on an on-going basis.

Skills of course need to be underpinned by knowledge – without it we can be good at engaging clients in the journey but the direction of travel may remain obscure. This chapter will take up the challenge of the quotation from Thomas Jefferson above, first by giving a brief account of the development of CBT and then by describing a set of simple CBT principles that emerged during this evolution.

THE NATURE AND EVOLUTION OF CBT

CBT is a family of models of psychological therapy based on the fundamental idea that psychological problems, such as anxiety and depression, are influenced and maintained by patterns of unhelpful ways of thinking, feeling and acting. Psychological problems often have specific types of thoughts that link naturally to specific patterns of unhelpful feelings and behaviours. Therapists formulate a model of client symptoms and their underlying patterns and then therapist and client collaborate to plan and implement a series of interventions designed to produce change for the better.

It is now commonly held that CBT has developed in three ‘waves’. The *first wave*, behaviour therapy, emerged between the 1950s and the 1970s. Behaviour therapists,

partly reacting against psychoanalysis, have been wary of speculating about inner thoughts and motives. They like to formulate difficulties and solutions in terms of explicit behaviours. They have an honourable history in formulating the first major alternatives to ‘medical model’ treatments in the field of psychiatry (Bruch and Bond, 1998).

The refusal to speculate about the inner life, however, probably limited the range of issues that the behavioural approach could deal with and so this gap was bridged nicely by the development of the *second wave*, cognitive therapy, and the subsequent integration of behavioural and cognitive approaches into CBT¹ between the 1970s and 1990s. Beck’s cognitive therapy for example shared the desire evident in behaviour therapy to develop what came later to be known as evidence-based practice, and both Beck and Ellis laid emphasis on behavioural change (Wills, 2009). Additionally cognitive approaches obviously had great interest in internal mental processes so that, as Rachman (1997, p. 17) puts it, ‘cognitive therapy is supplying content to behaviour therapy’. Weishaar (1993) notes the great enthusiasm with which the therapy field greeted the research showing the effectiveness of cognitive therapy for depression, and similar results became increasingly evident in other, diverse problem areas.

Eventually, however, the limitations of CBT became clearer and this has been a significant factor in the emergence of the *third wave*, which I would term ‘the mindfulness and acceptance wave’, from the end of the 1990s up to the present day. Mindfulness-based cognitive therapy (MBCT) was developed by Segal, Williams and Teasdale (2002) as an effective way of countering depressive rumination and hence is now a major factor in relapse prevention. The need for new interventions to deal more effectively with rumination showed some of the limitations of standard cognitive interventions to restructure negative thoughts. MBCT developed ways of helping clients to ‘view thoughts from another place’ and this has been echoed in other third wave models: acceptance and commitment therapy (ACT) shows that negative thoughts can be ‘defused’ rather than restructured, and compassion-focused therapy (CFT) has suggested that negative thoughts are best viewed from a stance of self-compassion. In light of these considerable changes, it can seem that there is a danger of CBT becoming fragmented. Wills with Sanders (2013) review the challenges of third wave developments and argue for integrating insights from them in a way that retains the simplicity and parsimony of the paradigm as a whole, and this book also shares this view.

THE PRINCIPLES OF CBT

The principles underpinning the CBT skills, methods and strategies described throughout this book uses the template of CBT principles, first described by Aaron Beck (1976; Beck & Emery with Greenberg, 1985) and further developed by his daughter, Judith Beck (1995) – see Figure 1.1.

¹The first use of the term ‘cognitive-behavioural’ seems to have been in 1972.

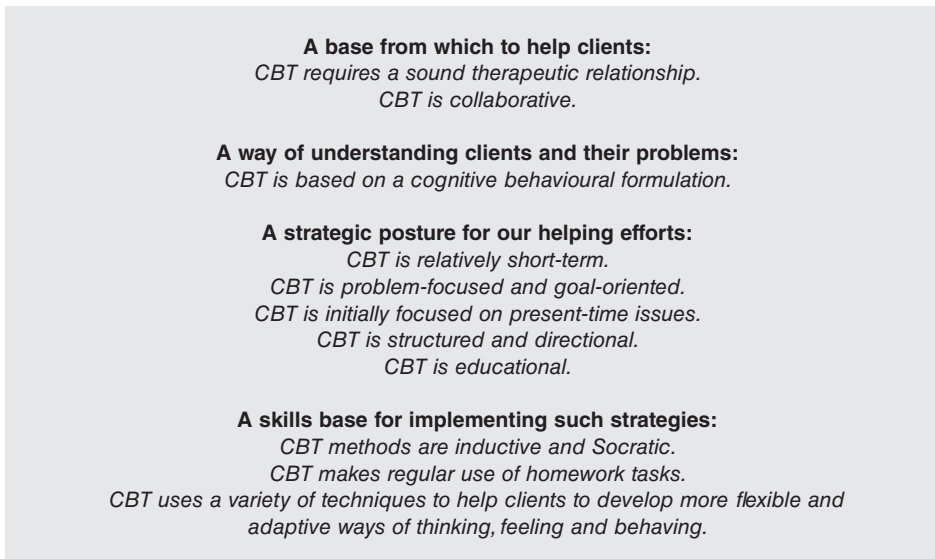


Figure 1.1 The principles of CBT (adapted from Beck, 1976; Beck et al., 1985; J. Beck, 1995)

The basic but evolving principles offer practitioners ways of developing clarity on:

- ◆ therapeutic relationships with clients
- ◆ concepts for understanding clients and their problems
- ◆ strategic postures for therapeutic interventions
- ◆ skills to implement strategies.

CBT works from a therapeutic relationship based on collaboration

I have sought to convince therapists from other traditions that CBT therapists really do believe that building a therapeutic relationship is an essential part of what they do. My argument has been based on three main propositions:

- ◆ The therapeutic relationship in CBT has significant heritage and continuity from other approaches to therapeutic work. This point is further explained under the heading, ‘Empathy, warmth and genuineness’.
- ◆ CBT has, however, its own particular take on the therapeutic relationship – see the section ‘A collaborative working alliance, empirical in nature and pragmatic in spirit’.
- ◆ Although the relationship in CBT aspires towards simplicity, in the right hands it can be practised with interpersonal sensitivity and can embrace skilled use of transference and counter-transference – see ‘Interpersonally sensitive CBT’.

Readers may find it helpful to regard the above as steps to guide their development in CBT. Newcomers to using CBT skills should concentrate on establishing empathy, warmth and genuineness and then add CBT collaboration to them. Finally as they become more aware of the subtleties of therapeutic work, they can begin to add in a more relational dimension to their work.

Empathy, warmth and genuineness

Beck, Rush, Shaw and Emery's (1979) description of the therapeutic relationship in their seminal work on cognitive therapy clearly owes a debt to the ideas of Carl Rogers:

As described by Rogers (1961) the therapeutic relationship in cognitive therapy is characterised by genuineness, respect and, within reason, warmth. (Beck et al., 1979, p. 21)

Cognitive theory, however, suggests that the way that clients see the therapist's empathy will be influenced by their belief system: helpers seen as empathic by some may seem patronising to others. Warmth in CBT is often accompanied by a degree of optimism; practitioners may sometimes choose to be a little 'upbeat' with the client, especially the depressed client. Judicious use of humour, not overdone, can help to reframe certain ways of thinking.

Empathy can be extended by the reflection of meaning as well as by reflection of feeling (Ivey, D'Andrea & Ivey, 2012). Cooper (2003) shows that exploring meaning is also a central concern of existentially based helping. A form of cognitive empathy develops as the understanding of feelings is enhanced by the expression of what those emotions mean. The CBT practitioner can make this link explicit by saying something like: 'Anyone who is thinking *I have lost everything* might well feel low, as you do now.' Blending reflections and Socratic questions extends empathy, rather as is done in motivational interviewing (Miller & Rollnick, 2002), and this is illustrated in the discussion of Guided Discovery through Socratic Dialogue (GD/SD) in Chapter 4. Empathy can be further enhanced by exploring how *emotion* drives – *motivates* – behaviour.² Empathic dialogue can also challenge clients, though there then may be a need for a degree of genuine tact: genuineness is a quality as important to CBT therapists as to others.

Helpers using CBT aim to bring these qualities together to form the basic therapeutic relationship and also to initiate 'collaborative empiricism' (see next section). A study by Arnow et al. (2013) showed that outcome in CBT is strongly linked to the quality of the relationship.³ The presence or absence of this relationship is often evident at a

²'Emotion' and 'motive' derive from the same Latin root word meaning to 'move' or 'excite' – i.e. emotions and motives both move us and cause us to act.

³It should however be noted that the form of CBT used in the Arnow et al. study is cognitive behavioural analysis system of psychotherapy (CBASP; McCullough, 2000, 2006). McCullough has put considerable effort into developing the therapeutic alliance for the specific client group – with chronic depression. There are dangers in assuming that all variants of CBT have the same efficacy status (Gilbert, 2009b).

very early stage of CBT. Furthermore, Keijsers, Schaap and Hoogduin (2000), in a major review of therapeutic qualities in CBT, show that CBT practitioners seem to be just as good at enacting these qualities as therapists in other traditions.

A collaborative working alliance, empirical in nature and pragmatic in spirit

CBT practitioners have gone out of their way to stress that the operation of the model does not depend on a clever expert being 'in charge': though CBT can be subtle it aspires to lack pretension and to be 'down to earth' (Wills, 2006a). This is why such emphasis is placed on forging a collaborative working alliance between practitioner and client. Collaboration, however, simply means working together: the client's work and the therapist's work are different but must dovetail with each other. CB therapists work to help clients to identify and, sometimes, challenge their thinking. Clients report as honestly as possible on ways they react to trigger situations. If they see that these reactions do not work for them, they can be helped to commit to developing alternative ways of thinking that work better for them. They may however experience challenges of their thinking as attacks on themselves. It can therefore be helpful to use analogies in which client and therapist form a 'team' against the problem. Client and practitioner share responsibility for work and progress. The collaborative structuring devices of agenda setting and collecting feedback (see Chapter 2) can bolster this process. Early in therapy, practitioners will probably take more responsibility and will be more active but responsibility and control can gradually be handed over to clients. The initial stance may be one of tutor-coach but, as time goes by, this may evolve more towards a consultative mode (Neenan & Dryden, 2013). The basic working alliance is a joint venture to collect, analyse and review information about the client's life and use it to discern new positive directions for the future.

Interpersonally sensitive CBT

Therapy is an inherently interpersonal process, and CBT is therefore subject to the same kind of interpersonal and relational processes as have been identified and used more explicitly in other models of therapy. Becoming more aware of interpersonal processes allows CBT practitioners to make more flexible use of structure (Chapter 2). Without some such flexibility there is danger that CBT can become stilted and lifeless. The way clients react to CBT methods varies enormously and therefore the real art and skill of practitioners is to find the particular way that interventions may work best for the individual client before them. Learning how to do CBT in a way that is sensitively attuned to individual clients must therefore be a life-long process (see Chapter 8). It seems natural to me for practitioners from different approaches to learn what they can from each other, and CB therapists are now showing more willingness to do so. A good example is the way that we have opened our constructs to an understanding of interpersonal processes (Gilbert & Leahy, 2007; Wills with Sanders, 2013). The discussion of interpersonal processes is further developed in Chapter 3.

CB therapists understand clients by making a cognitive behavioural road map

At the heart of the CBT paradigm there is a simple yet effective working model: the way people think about their situations influences how they feel and behave. It can be helpful to see if a client can work with this notion by using a dialogue such as the following to give a rationale for CBT:⁴

Practitioner (P1): I sometimes explain how CBT can work by telling a story about two people I knew. They both worked in the same factory and were of a similar age and family set-up. Sadly, one day they heard that they were both to be made redundant. One of them thought to himself, 'I am such a failure. My wife might well leave me.' Thinking like that, how do you think he felt?

Client (C1): Desperate, I should think. You know, really low and depressed.

P2: Yes, that's right, he did. Now the other guy thought, 'This is bad. It's scary. On the other hand, I'm not really happy there: maybe this is a chance to try out other things I'm interested in.' How do you think he felt?

C2: Well, better. He'd still be worried but he seems to have more hope.

P3: And if a job did come up, who would be most likely to go for it?

C3: The second bloke. The first one might give up: maybe not even apply?

P4: That's right and that's exactly what did happen.

Giving a story that seeks to explain the main conceptual thrust of CBT – as the example above illustrates, the idea that how one thinks about something influences how one may feel and behave in relation to it – can work because it shows two people reacting differently to much the same situation. This stresses the importance of the way the event is appraised. It is often helpful to fit examples to the client's interests or background and to reinforce the central idea by drawing diagrams (see Figure 1.2).

Some important points emerge from this example. First, bad things do happen in people's lives – their reactions are not all about their inner psychology. Second, the person who shows a more adaptive response is still 'concerned' about his or her situation: they are certainly not happy or blasé. Concern is appropriate in this context and would be more likely to motivate a person to actively engage in surmounting the crisis of redundancy, though sometimes allowing oneself a period of feeling the loss is helpful. More discussion on the positive use of negative emotions can be found in Chapter 6. Third, the diagrams constitute examples of 'cycles' – one 'vicious' and dysfunctional, the other more functional. In the 'vicious' cycle example, the emotional and behavioural

⁴A teaching and learning exercise based on this rationale can be found on the companion website for this book: <https://study.sagepub.com/wills>

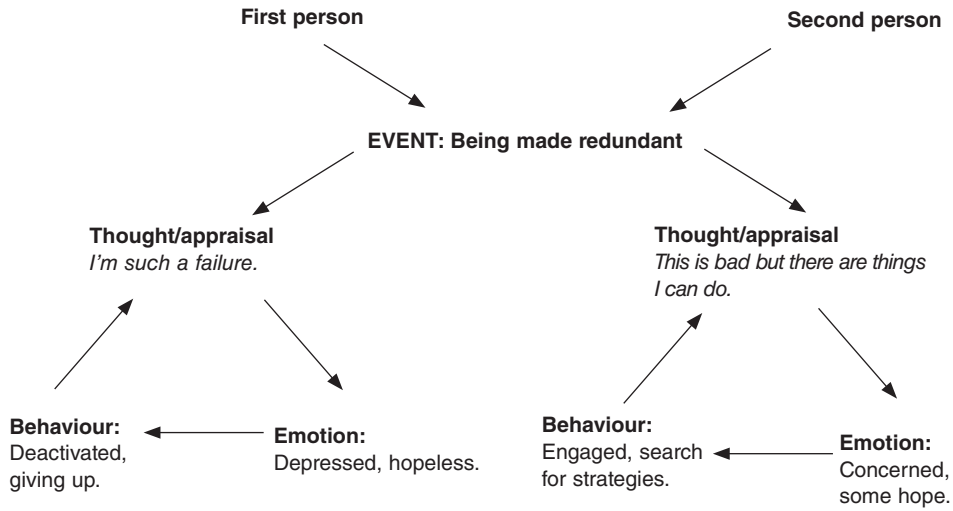


Figure 1.2 The 'vicious cycle' concept – two cycles compared

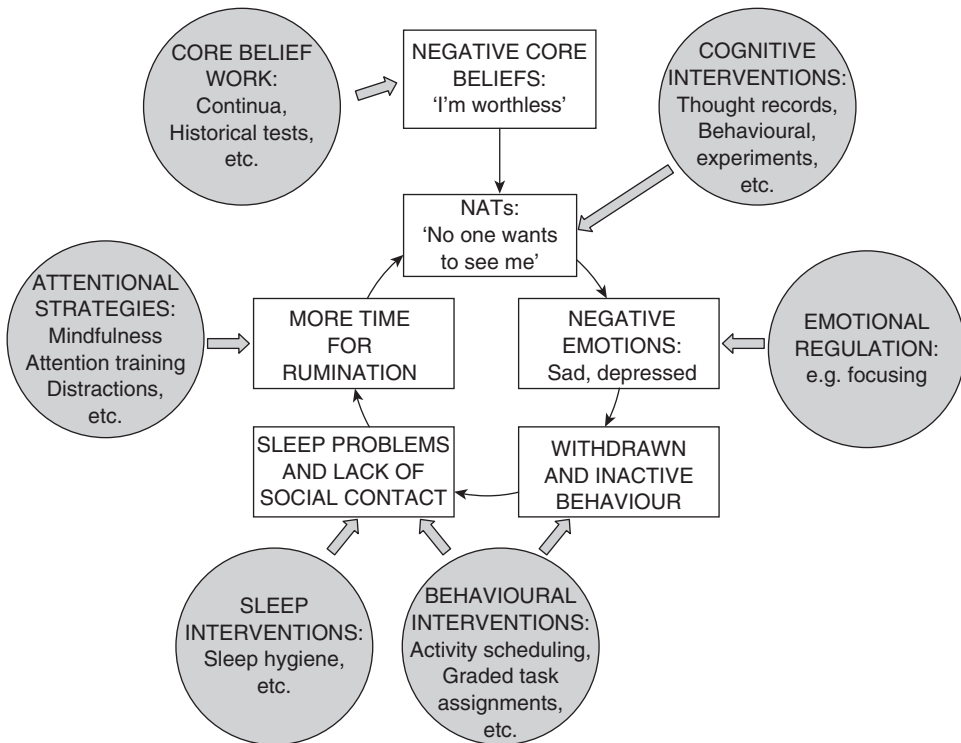


Figure 1.3 Vicious cycle with therapy targets

responses may well unwittingly confirm the prediction in the negative thought – what can also be termed a ‘self-fulfilling prophecy’. In contrast, the functional cycle offers more hope for resolving the problem. Finally, the separate elements of the ‘vicious cycle’ diagram can each be regarded as potential targets for a series of change strategies: triggers can be changed; beliefs and thoughts can be modified; emotions can be ‘worked through’; and ‘behavioural experiments’ can be tried (see Figure 1.3).

‘Vicious cycle’ diagrams are used frequently in CBT practice – sometimes drawn on a pad or on a whiteboard. They should be regarded as provisional, not set in stone: clients can draw them in their client notebooks and take them home to think about, play with and customise (see Chapter 2). It can be a powerful moment in therapy when clients first become aware of their own negative thoughts. ‘Seeing’ them written up on a whiteboard or in a client notebook can further enhance these moments.

The redundancy situation in the rationale-giving story above is one that can speak to many people, but the context may also be adapted to their own experiences, that is, situations in offices, schools and other places. Despite the modern setting of the example, it also carries an echo of the wisdom of the Socratic and Stoic traditions, most famously stated by Epictetus (1995), who said, ‘People are disturbed not by events *alone* but by the view they take of them’ (*Enchiridion, V*). Once again we note that ‘stuff happens’ – but we can have some control about how we react to events. Systematic consideration of ‘triggers’ also requires sensitivity to social, economic, political, ethnic and cultural factors that impinge on the well-being of us all (Gilbert, 2009a; Levinson, 2010).

Suggestion If you are working in pairs, role-play giving a rationale-giving story for therapy: perhaps along the lines of the ‘factory’ story above. Try, however, to amend the story to the situation of the person you are speaking to. This could be by changing the employment focus or shifting the scene to some other context that you think might speak to them: e.g. how, for example, might you put this to a child or young person?

If you are working by yourself, try to think of a story that would appeal to a recent client.

A simple ‘vicious cycle’ diagram is often the first step in the formulation of the client’s situation in CBT terms. Further steps can take the form of recognising cognitive distortions in negative thoughts and looking for thoughts commonly associated with problems like anxiety and depression. ‘Catastrophisation’, for example, is often very evident in thinking connected to anxiety (Barlow et al., 2011). Finally, adding beliefs that relate to these thoughts completes the map. These concepts are more fully described in Chapters 2 (Skills for Assessing, Formulating and Starting CBT), 4 (Skills for Working with Negative Thinking) and 7 (Skills for Working with Enduring Life Patterns).

Cognitive factors include information processing, attention and interpretation. Cognitive therapy could easily have become known as ‘appraisal therapy’ because it is

the cognitive processes of appraisal that are really the most important to successful CBT work. Most automatic thoughts are about trivial matters. The negative thoughts of clients that most often turn out to be relevant in CBT are almost always linked to appraisals of meaning connected to who clients think they are, what they think they should be doing, and with whom they think they should be doing it. The development of mindfulness in therapy also shows us the importance of the way clients may be paying attention to their negative thoughts. Mindfulness suggests that we can both think and be aware of thinking. Helping clients to relate to thoughts by thinking 'I am having the thought that ...' can help them step a little outside negative thoughts and, in a sense, learn to not take them so seriously. Readers should bear this in mind as we shift through different layers of thinking, attention, appraisal and meaning.

Suggestion Think back over the last few weeks and search for an incident where you felt a strong emotional reaction. For the purpose of this exercise, it is usually best to think of a negative emotion that you *half know* is a little problematic (for example, where you reflect that something got to you more than it *should* have done). See if you can trace out your reaction in terms of the pattern of trigger–thinking(appraisal)–emotion–behaviour. If possible, draw out as shown above.

Is there any element of a 'vicious cycle' in the reaction chain you have identified? If such a situation arose again, how else might you choose to react? What did/does this situation MEAN to you?

CBT has characteristic ways (strategies) of approaching helping clients

Short-term therapy

CBT is often associated with shorter-term work, perhaps in contexts such as the NHS, which are necessarily resource-conscious and have stressed the need for shorter-term methods. The usual range of formal CBT – between 10 and 20 sessions – would once have seemed impossibly short to some, but now I am frequently told it seems luxurious compared to the framework of 6–8 sessions⁵ that many have to work in. The range of between 10 to 20 sessions emerged from research on CBT with depressed clients that suggested that the most parsimonious results came from a mean of 17 sessions (Beck et al., 1979). A theoretical justification for shorter-term work, however, stresses the fact that the collaborative alliance between practitioners and clients rarely solves all client problems and should therefore be focused on facilitating clients to solve their own

⁵A number of sessions now frequently specified in employee counselling and in the Health Service (Reeves, 2012).

problems by becoming their own therapists. This would help clients avoid future relapse and this seems to be one of CBT's main strengths – a review by DeRubeis, Siegle and Hollon (2008) shows that cognitive therapy is as efficacious as anti-depressant medications in long-term outcomes in the treatment of depression, supported by neuro-scientific evidence. Short-term work is, in my experience, popular with clients, especially if they can request extensions if they so wish. As CBT has expanded to address more complex problems, however, longer-term versions of it have developed (see Chapter 7).

Problem and goal focus

CBT has initial preference for short-term work and this is important because it influences other aspects of working style. When a CBT approach is offered as a brief intervention, it is helpful for practitioners both to use educative materials and to use limited time with clients well. It is good therefore to be focused, and one – but not always the only – focus is the problem and/or symptoms that the client brings. A clear problem focus leads naturally to agreed goals. As Egan (2013) has pointed out, goals are the flip side of problems.

Present-time focus

As problems are assessed and a formulation of them is built up, it is often apparent that although there is a problem in current functioning, this problem has a 'history' and may be reflected in early development. CBT often begins with an inclination to work with the current, present-time problem and has placed somewhat less emphasis on historical and developmental factors. This aspect of CBT developed because much of its theory and practice came from focusing on clear syndromes with relatively discrete symptoms, such as unipolar depression (Beck et al., 1979) and panic disorder (Clark, 1996). As CBT has expanded into wider areas, however, it has become noticeably more flexible in terms of both length of contact and in attitudes towards working with more historical and developmental issues (Wills with Sanders, 2013). If we maintain that CBT is essentially a set of principles and methods that can be applied quite flexibly then we can also take a more flexible stance on length of therapy. Longer-term versions of CBT have emerged in the form of dialectical behaviour therapy (Linehan, 1993, 2004) and schema-focused therapy (Young, Klosko & Weishaar, 2003). This new flexibility means that CBT interventions may develop in a variety of different ways. They may centre on 'standard' work with current symptoms within the traditional short-term framework. If this work is relatively successful, yet underlying issues are evident and the client wants to work with them, work can refocus on those underlying issues, perhaps even within the range of short-term interventions. It is not always necessary to completely 'work through' all these issues so that therapy may still be completed within a short-term time frame. Alternatively, there are criteria⁶ that can inform a judgement on whether 'standard CBT' would not be a suitable approach for this particular client (Young et al., 2003), and therefore therapists may then use a longer-term, schema-focused model, perhaps

⁶These criteria are reviewed in Chapter 7.

going up to and beyond 40 sessions or lasting for longer than one year. Carefully researched work by Cummings and Sayama (1995) suggest that most caseloads will carry around 10% of clients who will need longer-term help and 5% who may even need to keep coming back for periods of therapy over many years. The title of a paper by McGinn, Young and Sanderson (1995) nicely captures a growing mood in CBT: ‘When and how to do longer-term therapy and not feel guilty’. It is interesting that short-term versions of psychodynamic therapy are now based on the fact that many clients do not stay that long in therapy (Levenson, 1995) and one version has produced good efficacy results for the treatment of panic (Busch, Milrod, Singer & Aronson, 2012). This treatment is, however, longer than the usual CBT treatments, though it may be especially useful when panic is associated with interpersonal difficulties.

Structured and directional

As clients may be experiencing some chaos in their lives, therapy structure can be helpful to them. Structured steps should however be used with a ‘light touch’ and fitted to the needs of the client – see Practice tip on p. 16. Most clients expect some direction but this should be supplied in a ‘directional’ rather than a ‘directive’ way (see Wills with Sanders, 2013, p. 30).

Educational focus

Another factor that emerges from these short-term and problem-solving strategic postures is that CB practitioners have traditionally taken a consciously educational role. This role may be relatively didactic, exemplified when the therapist gives a depressed client ‘normalising’ information about the condition. A client, for example, may become overly self-critical because of poor concentration and motivation, and it is often helpful for them to realise that these traits may well be ‘the depression speaking’, and are not the client’s inherent personal qualities. This kind of normalisation also carries a meta-message typical of CBT: *This is something we can learn to manage*. There is a more subtle aspect to the educational role, one that is closer to the ‘tutor-coach’ role. In this mode, the therapist’s role is to help clients to ‘learn to learn’. This begins by trying to foster the quality of reflective curiosity in the client: *What is happening to me?* Gradually reflection may become more active as the client learns to ‘think about thinking’ and to regard their behaviours in more detached and mindful ways so that new responses can become more possible.

A skills methods base for implementing strategies

Inductive and Socratic Guided Discovery

CBT practitioners use their methods based on the aim of encouraging clients to develop realistic views of the predicaments in which they find themselves. They do this but not without first helping clients to test their current negative views of their

lives. This is referred to as an inductive process because it starts with observations and then tests the implications of these observations for current theory. The aim of this reality testing is to create cognitive dissonance that in turn promotes changes of mind. The use of Socratic questions is central to CBT (Wills, 2012), and I call this process Guided Discovery through Socratic Dialogue (GD/SD). Mindfulness theory suggests to me that the effectiveness of GD/SD is likely to come from, not as we first thought, changing the content of thought but from *changing the relationship clients have to the way they think*. This perspective on cognitive work is described in Chapter 4.

Homework

Homework completion is associated with greater gains in CBT practice (Kazantzis, Deane, Ronan & L'Abate, 2005) and may be increasingly regarded as a 'common factor'⁷ (Kazantzis & Ronan, 2006) in all kinds of helping. Using the time between sessions for these activities also helps to compensate for having less time when working within time limits with some clients. All in all, time limits can have positive as well as negative effects.

A variety of techniques and methods

CBT skills and techniques will be described more fully in the rest of this book. Here the focus is on showing the relationship between skill use and principles of CBT that influence why and how client problems are addressed in the way they are in CBT.

We can for example see the GD/SD process at work in the rationale-giving stories presented earlier. Then we discussed the role of these stories in building up the client's understanding of what therapy is aiming to achieve. Another rationale-giving story uses a common experience that will be known to many: greeting someone on the street who apparently 'blanks' them. Many people, when asked their thoughts on this scenario, report thinking either 'He doesn't like me' (sad external appraisal) or 'What a bastard' (angry external appraisal), or 'I must have done something wrong' (internal appraisal). If we encounter this situation when feeling confident, we might stop the person and ask, 'Didn't you see me?', and might then get some information about what happened. More likely, though, we will review the situation and perhaps reflect, 'Have I done anything that might have offended him? I can't think of anything. Perhaps he was just distracted.' We are essentially 'reviewing the evidence' – a normal everyday cognitive activity. If we were feeling low when we were 'blanked', however, we'd probably be more upset and would be much less likely to act assertively. Even later, we may still find it hard to 'review the evidence' and come to a more positive view. It should be acknowledged too that we may never know the absolute truth of the situation but can usually be sure enough to put the experience behind us.

An upsetting but isolated incident is not usually the main cause of mental health problems. Once psychological problems start to develop, however, these incidents may

⁷A 'common factor' may be defined as something that is helpful to therapy and occurs across all or most models of practice.

tend to increase and take their toll. Once a tipping point is reached, symptoms may occur in a syndromal way and then kick-start 'vicious cycles' of yet further symptoms.

Breaking into these vicious cycles with therapeutic interventions may well begin with behavioural work. In depression, for example, the effects on concentration may make any kind of higher-order cognitive work too difficult, at least for a while. As we will see in Chapter 5, however, 'activation' – increasing levels of behavioural activity and encouraging more proactive behaviours – can result in steady improvements in mood that in turn make cognitive work and cognitive shifts more possible. Sometimes a behavioural change alone can shift thinking. I might, for example, hold the negative and depressing belief 'I can't make myself heard at work', but if I do find a way of making myself heard and see for myself that I have done so, my belief systems, faced with dissonant cognitive information, may shift to take in this new information.

Cognitive change takes place at different levels. Negative automatic thoughts (NATs) are everyday processing events which may be modified by techniques such as 'reviewing the evidence' and thought records (see Chapter 4). These techniques essentially help the mind to process information as it does when functioning well. Sometimes evidence is written down in a client notebook or on a whiteboard, and this helps clients to be more aware of their thinking processes. Having completed this task in the session, the client might be encouraged to keep it up as a homework task.

Getting clients to write down things for themselves supports their responsibility for, and control of, change. It can be easy for a persuasive practitioner to think up good challenges to NATs. The change that comes from practitioner challenges, however, may be short-lived and may not get the client into the habit of being her or his own therapist. This emphasis on getting the client to do work may be one of the reasons why CBT therapists report fewer problems with client dependency than other types of therapy. Recent approaches to CBT have stressed the fact that traditional cognitive restructuring can be overdone, and clients may at times be better encouraged to 'defuse' negative thinking by regarding it more mindfully.

As well as working on NATs, CBT practitioners are likely to build up experiences of working with deeper levels of cognition in the forms of assumptions, rules of living, core beliefs and schemas. These interventions are typically more complex and long-term and involve using more interpersonal, emotionally and mindfulness-based, and relationship-based, factors (see also Chapters 3, 6, 7).

It can be seen that CBT uses a variety of techniques to change thinking, mood and behaviour. The book concludes by discussing both how to integrate all these skills into an overall model and how to establish a process of on-going skills development.

CONCLUSION

CBT is a skill-oriented form of practice that combines general therapy skills with CBT-specific skills.⁸ CBT-specific skills are located within a set of principles governing how to understand client problems and how to help in the collaborative planning with clients on the way to jointly implement interventions to ameliorate such problems.

⁸Further references on the mix of general and specific skills are given in Chapter 8.

The principles are adaptable but serve as navigational devices to keep the CBT ship on course and to steer clear of the shallow waters of banality and the stormy waters of chaotic therapy.

Follow-up suggestion Looking back at the principles in Figure 1.1, which of them are you in ready agreement with? Are there principles that are more difficult to accept? If you had to 'sign up' or 'take the oath' for this set of principles and could amend one or two, which ones would they be and how would you amend them?

PRACTICE TIP: TITRATING CBT STRUCTURE

Learning to use therapy structure in a way that is comfortable to each individual client is very much one of the main skills of the art of CBT. We probably begin with the assumption that the therapy will be quite structured while at the same time retaining an exquisite sensitivity (Beck et al., 1979: 65) to individual client needs in this and other areas. Beck et al. (1979) refer to 'titrating' the degree of structure. Structure, for example, is often helpful to depressed clients because it helps them concentrate and remember. Many clients come from other therapists complaining of being subjected to over-long silences, during which they felt worse. Interestingly, they have often interpreted these silences as meaning that the therapist did not care about their problems. While I am sure that they were mostly wrong in this assertion, it does remind us of the cardinal cognitive principle that people will understand what is happening to them in terms of their current thoughts and feelings. As in the previous tip, words are very important here too. Many therapists working in other models seem to think that it is very bad for the therapist to be 'directive', but what about a therapy that 'lacks direction' or a therapist who is not able to communicate 'directly'? All these words and phrases are related to each other. Therapists should be aware of the client's language and meaning: they may frequently find that they are not derived from reading therapy books.

FURTHER READING

Rachman, S. (1997) The evolution of cognitive behaviour therapy. In D.M. Clark & C.G. Fairburn (Eds.), *Science and practice of cognitive behaviour therapy* (pp. 3–26). Oxford: Oxford Medical Publications.

Wills, F., with Sanders, D. (2013) *Cognitive behaviour therapy: foundations for practice*. London: Sage. (Especially Chapter 1)