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Brief Cognitive Behaviour Therapy

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Stephen Palmer
& Peter Ruddell

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The Cognitive Behaviour Framework

A Whistle-Stop Tour

This chapter will briefly outline the basic principles and practices of cognitive behaviour therapy. A central principle of cognitive behaviour therapy is that thoughts, emotions, behaviours and physiology are part of a unified system. A change to any one part will be accompanied by changes to the other parts. For example, if a person's television exploded as she watched it, she may experience immediate physiological changes (a surge of adrenalin); a rapid shift of behaviour (from calmly watching the screen to rushing for a fire blanket or to telephone for help); a feeling of anxiety and thoughts or cognitions such as '!*!*!*: the house is burning I'm going to die'. Cognitive behaviour therapy recognizes the unified nature of this process. The scenario presented here does not represent a psychological problem, but where psychological problems exist, change is sought through focus on unhelpful thoughts. It is important to stress that components such as emotions and behaviours are not ignored or considered unimportant and we will demonstrate in later chapters how these are given full consideration in a process which brings about therapeutic change.

In reading about the exploding television, you may have thought that you would not have experienced a rush of adrenalin or felt or acted in the same way. Cognitive behaviour therapy accounts for this by suggesting that each person brings to a situation a different range of feelings, physiological responses and behaviours, and that thoughts guide these. Feelings and responses are not caused intrinsically by the situation itself, but largely by the way in which each of us views it. This was realized at least as long ago as the first century AD when the stoic philosopher Epictetus noted that people 'are disturbed not by things but by the views which they take of them'. Well known theorists and creators of various therapeutic approaches have taken a similar view, including Arnold (1960); Beck (1964); Ellis (1962, 1995); Kelly (1955); and Lazarus (1997).

Beck developed cognitive therapy and his work initially centred on depression (1963). The central themes of cognitive behaviour therapy are:

- that thoughts can trigger emotions and behaviour;
- that emotional disorders arise from negatively biased thinking (which leads to unhelpful emotions and behaviour);
- that emotional disorders can be helped by changing such thinking (which is assumed to be learned).

Two components of thinking are focused upon in cognitive behaviour therapy: automatic thoughts and underlying beliefs.

Automatic thoughts

'Automatic thoughts' was a term given by Beck to the thoughts and images which occur involuntarily in a person's stream of consciousness (Beck and Greenberg, 1974). Similar terms are 'internalized statements', 'self-statements' or 'things you tell yourself' (Ellis, 1962), and 'self-talk' (Maultsby, 1968).

Underlying beliefs

These are the beliefs and assumptions which generate the thoughts and images forming the content of automatic thoughts. The relationship between automatic thoughts and underlying beliefs can be better understood by briefly considering the idea of schemas. Schemas are abstract mental plans that serve as guides to action, as structures for remembering and interpreting information and as organized frameworks for solving problems. Each of us adopts a vast range of schemas which allow us to make sense of the world and to place any new information or experiences into context (e.g. see Rosen, 1988; Rumelhart, 1981; Rumelhart and Ortony, 1977; Young et al., 2003). They are like vast filing systems which each of us uses to order the world and which begin to be formed from early childhood. Once formed, they guide information processing and behaviour (Bartlett, 1932) and shape how a person thinks, feels and behaves concerning self, others and the world. Importantly, they are hierarchical. For example, matter can be perceived as animate or inanimate; animals as vertebrates or invertebrates and so on (see Figure 2.1).

Similarly, in the case of the exploding television, a person who holds an underlying belief (i.e. a belief further up the hierarchy) such as 'fire always causes death' is likely to feel panic stricken and beset with automatic thoughts such as 'I am going to die', accompanied by negative images such as a charred body engulfed by fire. The person who holds the belief that 'fire is dangerous if not controlled' may feel sufficient concern to act appropriately and may experience automatic thoughts such as 'cut the electrics and get help now', accompanied by helpful and constructive coping imagery. A person who holds a belief at the top of the hierarchy, such as 'life is dangerous', will be predisposed to anxiety in a wide range of situations. A belief such as this, at the top of a hierarchy and affecting a large portion of a person's life is known as a core belief.

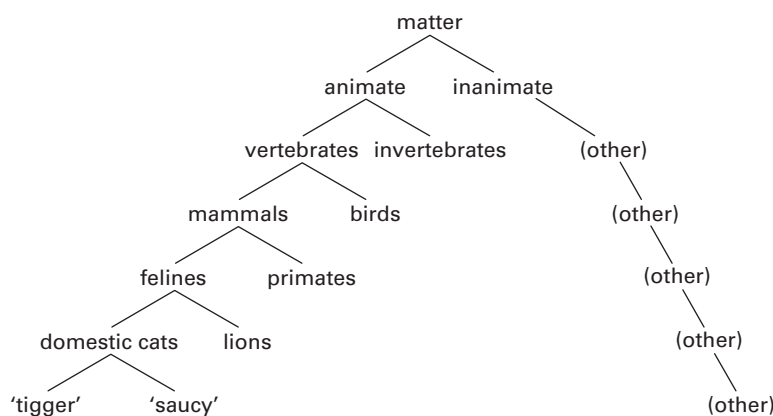


Figure 2.1 *Schema representation*

We follow Beck's view that the schema is the cognitive structure (or 'filing system') within the mind, whereas the core belief is the specific content (Beck, 1964), but a number of practitioners use the two terms interchangeably (Padesky, 1994). Core beliefs operate at a rudimentary level and are global, rigid and over-generalized.

Intermediate beliefs

Between core beliefs and automatic thoughts lie a number of intermediate beliefs (Figure 2.2). Intermediate beliefs are composed of attitudes, rules and assumptions:

Attitude: It is dreadful to be in danger.

Rule (expectation): I must always be safe and act with caution.

Underlying assumptions: If I always act with caution then life will be less dangerous.

If I don't act with caution then life will be dangerous. (The corollary assumption.)

We have briefly outlined the cognitive structures that hold the key to psychological difficulties which individuals experience. How does a cognitive behaviour therapist help a client to overcome these difficulties through brief therapy? Obviously, basic counselling skills are a prerequisite and are identified by Truax and Carkhuff (1967) as follows:

- 1 Be accurately empathic.
- 2 Be 'with' the client.
- 3 Be understanding, or grasp the client's meaning.
- 4 Communicate empathic understanding.
- 5 Communicate unconditional positive regard.

<i>Core beliefs</i>	<i>Intermediate beliefs</i>	<i>Automatic thoughts</i>
Global	Attitudes	Stream of thought
Rigid	Rules/expectations	Images
Over-generalized	Assumptions	Words/phrases

Figure 2.2 Schemas

While these are basic counselling skills, there are a number of characteristics fundamental to cognitive behaviour therapy which enable the therapist to help the client by explaining, exploring and building upon the principle of thoughts leading to feelings and behaviours and some bodily reactions, as described above. Some therapists find it useful to symbolize this principle as ABC (Ellis, 1962, 1977, 2003), as indicated below:

- A = *Activating event*: e.g. television exploding.
- B = *Belief*: e.g. 'I'm in grave danger'.
- C = *Consequence*: e.g. anxiety.

The A (activating event or adversity) may be an actual event (such as the exploding television), an experience or even a thought, daydream, image or emotion about which

a person might have thoughts or beliefs. The B (belief) may be a core belief, an underlying assumption, an intermediate belief or an automatic thought. ‘Many times, maladaptive ideation occurs in a pictorial form instead of, or in addition to, the verbal form’ (Beck, 1970). The C (consequence) may be anything the thought or belief (B) leads to, such as an emotion (fear), a behaviour (running away) or a physiological response (palpitations).

Cognitive behaviour therapy progressively encourages the client to recognize and accept their emotions, to detect first their automatic thoughts and then the related underlying beliefs (both intermediate and core). Only if the connection between thoughts (beliefs) and emotions (consequences) is recognized can further progress be made through cognitive behaviour therapy. Once this process is started the client is encouraged to look for evidence in support of unreasonable and unhelpful beliefs. The inability to find such evidence poses a challenge to such unhelpful beliefs, which are in turn transformed into more adaptive, helpful beliefs. These new and more realistic beliefs no longer support the distressing emotions and behaviours. To aid this process, an *automatic thought form* is commonly used (see item 7, p. 18, and Figure 2.7, p. 19). Beliefs and emotions are rated to aid belief change and evaluation over time (see scaling beliefs, p. 69).

Thinking Errors

Thinking errors are also known as cognitive distortions or twisted thinking (Burns, 1980, 1989). Identifying automatic thoughts and recognizing the thinking errors contained within them play major roles within cognitive behaviour therapy. Individual clients tend to make consistent errors in their thinking. The therapist helps the client to identify these errors or cognitive distortions. Clients are introduced to the notion that when people feel emotionally distressed they often have accompanying thoughts which seem believable at the time but which on closer scrutiny are not always consistent with objective reality and are unhelpful to the client. Most of the negative thoughts which disturb a client are distorted and unrealistic. A client will be taught how to identify the thinking errors which lead to negative moods. It is important to convey to the client that they are not alone in having these distortions. They are common to humankind but proliferate with emotional distress. We identify the most common thinking errors in Figure 2.3.

1 All or nothing thinking (also known as dichotomous thinking)

This is where a client evaluates herself, other people, situations and the world in extreme categories. This type of thinking tends to be absolutist and does not allow for shades of grey. An example is the young mother who views herself as all bad because she becomes frustrated with her young child and views other mothers as always being patient with their children. So she sees other mothers as all good and herself as all bad, which is unrealistic.

2 Personalization and blame

Personalization is a thinking error in which a person totally blames himself for all that goes wrong and relates this to some deficiency or inadequacy in himself. He holds himself personally responsible for an event which is not entirely under his control.

- 1 All or nothing thinking
- 2 Personalization and blame
- 3 Catastrophizing
- 4 Emotional reasoning
- 5 Should or must statements
- 6 Mental filter (selective abstraction)
- 7 Disqualifying or discounting the positive
- 8 Over-generalization
- 9 Magnification and minimization
- 10 Labelling
- 11 Jumping to conclusions (arbitrary inference)
 - Mind reading
 - Fortune telling

Figure 2.3 *Thinking errors*

An example is the young trainee who believes her trainer is brusque with her because she made a mistake. She overlooks the part others may play and confuses the possibility that she may have contributed to what happened but was not totally responsible. The opposite is to blame others. She blames others for her problems or circumstances and does not believe she has contributed to the problem. An example is the man who totally blames his wife for the break-up of their relationship.

3 Catastrophizing (fortune telling)

This is where the person predicts the future negatively and believes things will turn out badly. This thinking error is common with anxiety problems (Ellis, 1962) where clients tend to dwell on the worst possible outcome of any situation. An example is the successful manager about to make a presentation for the company. She becomes preoccupied with thoughts that she will make a mess of her presentation, let down her company, lose her job and become destitute.

4 Emotional reasoning

This is where a person draws conclusions about an event based entirely upon their feelings and ignores any evidence to the contrary. For example, the young man who has been waiting 30 minutes for his new partner to arrive feels sad and rejected. He says to himself, 'I've been ditched' and fails to consider that his partner may have been delayed at work, missed the bus, got a flat tyre, etc.

5 Should or must statements

This is where the person has a fixed idea of how she, others or the world 'should' or 'must' be. Preferences or expectations are elevated to rigid demands. When these demands are not met the person feels emotionally distressed and over-estimates how bad it is that her expectations have not been met. For example, the gymnast performing a difficult manoeuvre on the parallel bars said to herself, 'I really shouldn't have made so many mistakes'. This led to her feeling so angry and frustrated with herself that she did not practice for many days.

6 Mental filter (selective abstraction)

The person pays particular attention to one negative detail and dwells on it endlessly, regardless of any other positive aspects. He does not view the picture as a whole and only concentrates on one negative aspect. For example, an architect receives many positive comments about how he tackled a difficult work project. However, one colleague was critical about one aspect of the project. This comment played on his mind for a couple of days.

7 Disqualifying or discounting the positive

This is where the client ignores the positive of any situation and tells herself that these positive experiences do not count. For example, a father cooks good meals on most occasions for his family, but does not give himself any praise. He produced a nourishing but unappetising meal on one occasion and thought of himself as being an awful and unimaginative cook.

8 Over-generalization

The person thinks that because an unpleasant experience happened to her once, it will always happen. This is where she makes sweeping generalized conclusions on the basis of one situation. For example, a woman who attended a job interview but did not get the position believed she would be rejected for every job.

9 Magnification and minimization

The person who makes this thinking error when evaluating himself, other people or situations will tend to exaggerate or magnify the negative components and minimize or play down the positive. When being appraised at work he over-estimates the importance of some areas where change is needed and pays little attention to a considerable range of positive aspects highlighted by the appraisal. He concludes that this shows he is inadequate.

10 Labelling

This is where the person views herself or others in all or nothing terms but goes beyond this by applying a label which is usually derogatory. For example, the mother we referred to in item 1 might label herself 'a heartless bitch'. When this thinking error is applied to others a client dislikes or disagrees with, he may say to himself, 'He's an arse'. The client will see the person as globally bad and may then feel angry and hostile. The client who makes an error at work may label herself as 'totally stupid'.

11 Jumping to conclusions (arbitrary inference)

A person whose thinking is distorted in this way infers that a particular outcome will be negative, without having any evidence, or even if the evidence points to a positive outcome. There are two main types of this thinking error:

(a) Mind reading

The client thinks she knows what others are thinking and does not consider other more plausible or likely possibilities. An example would be the client with social anxiety who thinks her work colleagues see her as inadequate in a wide range of situations.

(b) Fortune telling

A person predicts that events in the future will turn out badly. For example, a person attending a routine chest X-ray assumes he has cancer (see ‘Catastrophizing’ above, where fortune telling is greatly exaggerated).

Clusters of thinking errors

It is important to note that a particular automatic thought, belief or inference may contain not one, but several of these thinking errors and we will exemplify this later. In introducing these thinking errors, we noted that an individual may tend to make consistent errors in their thinking. For example, a particular person may frequently use a cluster such as jumping to conclusions, ‘should’ statements, emotional reasoning and magnification/minimization. Similarly, emotional problems such as anxiety, depression or guilt each tend to have a prominent cluster of cognitive distortions or thinking errors surrounding them. Figure 2.4 gives the clusters of thinking errors common to particular emotional problems. This can be used as an aid to help the therapist to identify the most significant thinking errors for a particular problem. However, it is important to note that the clusters which a particular individual brings to a specific emotional problem will frequently have an idiosyncratic element.

Anxiety panic, nervousness	Depression	Anger	Guilt	Hurt	Morbid jealousy	Shame/ embarrassment	
	✓	✓		✓		✓	All or nothing thinking
	✓	✓	✓	✓		✓	Personalization/blame
✓	✓				✓	✓	Catastrophizing
✓	✓			✓			Emotional reasoning
✓	✓	✓	✓	✓	✓		‘Should’ or ‘must’ statements
	✓		✓		✓	✓	Mental filter
✓	✓						Discounting the positive
✓	✓	✓					Over-generalization
✓	✓			✓			Magnification/ minimization
		✓	✓			✓	Labelling
							Jumping to conclusions
✓	✓	✓		✓	✓	✓	(a) Mind reading
✓	✓					✓	(b) Fortune telling

Figure 2.4 Thinking errors for common problems

Fundamental Characteristics of Cognitive Behaviour Therapy

So far in this chapter, we have outlined the mechanisms by which a person experiences emotional difficulties or distress. In the next section we will guide you through the

fundamental characteristics of cognitive behaviour therapy by which this model is applied to the client's problems. Figure 2.5 is a list of the fundamental characteristics of cognitive behaviour therapy.

- 1 Therapeutic style
- 2 Formulation of problem
- 3 Collaborative relationship
- 4 Structure to sessions and to therapy
- 5 Goal-directed therapy
- 6 Examines and questions unhelpful thinking
- 7 Uses range of aids and techniques
- 8 Teaches client to become own therapist
- 9 Homework setting
- 10 Time limited
- 11 Audio-recording sessions

Figure 2.5 *Fundamental characteristics of cognitive behaviour therapy*

1 Therapeutic style

We start with therapeutic style because this is often quite different in cognitive behaviour therapy to some other forms of counselling. In cognitive behaviour therapy, it is assumed that the therapist brings to the therapeutic encounter a range of skills and knowledge. From this it follows that the therapist, particularly in the early stages of therapy, directs the course of therapy. The therapist's style is therefore active and directive. The therapist is sensitive to balance this with communicating empathic understanding and being 'with' the client, together with grasping the client's meaning (see items 2, 3, 4, pp. 10–11). Part of this style is about the ability to elicit information appropriate to the client's problems that will include the client's cognitions. The therapist also seeks out client strengths that may aid the change process.

2 Formulation of problem

The therapist gathers a wide range of information about the client and her problems. This is based not only on verbal information from the client but also on the therapist's own observations. A full assessment is carried out early on in therapy (discussed more fully in Chapter 3) and a *cognitive formulation or conceptualization* of the client's problems is made. This is constantly revised in the light of new information. In particular, the therapist identifies current thinking associated with and maintaining problematic behaviours and emotions, precipitating factors connected to the current problem and reinforcing unhelpful beliefs, and the client's unhelpful interpretation of major developmental events. The cognitive conceptualization is more fully discussed in Chapter 3.

3 Collaborative relationship

The therapist is open about his formulation and usually shares it with the client at some point for discussion together and for further development. Unlike some forms of therapy, cognitive behaviour therapy is transparent and does not present therapy as magical.

It is psychoeducational and informs the client (in easily understood language) about the process of therapy. To this end, reading material (i.e. bibliotherapy) is often used (Lazarus, 1971; Macaskill and Macaskill, 1991). The therapist socializes the client into such aspects as recognizing automatic thought, or in particular, negative automatic thoughts (NATs) and other unhelpful beliefs, and recommends certain courses of action such as homework, but encourages the client to participate fully and to take over responsibility for many aspects of therapy from an early stage.

The openness of therapy is further aided by client and therapist setting an agenda together for each session, as well as giving and receiving feedback. Through such collaboration and by using other therapeutic skills not specific to cognitive behaviour therapy (outlined above), the therapist quickly establishes a therapeutic relationship with the client. With some clients who have deep and far reaching psychological problems (as may be the case when working with people with personality disorders) it may be necessary to take more time and care in ensuring this is firmly established before entering too far into therapy, as outlined elsewhere in this chapter. Where this is so, brief therapy may not be appropriate unless a discrete and limited problem area is being worked with (see Beck et al., 1990a).

4 Structure to sessions and to therapy

As discussed in the last section, sessions are structured by an agenda, the contents of which is collaboratively agreed upon by therapist and client. The agenda has a common format applied across all sessions except the first. Although it need not be slavishly adhered to, the novice therapist is best advised to follow it during their course of training. The use of the agenda has several benefits which become more pronounced in brief therapy. It allows the client and therapist to use their limited time most efficiently. It helps to ensure that important material which client or therapist wish to bring to the session is not left to the end or entirely forgotten. It also aids collaboration by encouraging a problem-solving and business-like attitude (rather than encouraging a 'patient' or 'sick' role). The agenda also provides a convenient framework for monitoring progress throughout therapy. It gives a structure to help the client to understand the central themes of cognitive behaviour therapy and to apply this structure to herself once therapy is terminated. The structure of a typical session is as follows:

- 1 Check client's mood.
- 2 Brief review of week.
- 3 Set agenda for current session.
- 4 Feedback and link to previous session.
- 5 Review homework.
- 6 Discuss agenda items.
- 7 Negotiate homework.
- 8 Seek feedback at end of session.

The structure of therapy has a number of elements which are concerned with effectiveness and efficiency. These elements of cognitive behaviour therapy are relatively constant over its course, but some aspects change as therapy progresses. Cognitive behaviour therapy recognizes that different stages are involved and optimizes this

development by incorporating relevant tasks and responsibilities (for client and therapist) at the pertinent stage. For example, identifying negative automatic thoughts will be central to the start of therapy, while modifying core beliefs will usually not be attempted until later in the process. In brief therapy the therapist may also alert the client to the positive automatic thoughts (PATs) and helpful intermediate and core beliefs he may already be using in many situations. The structuring of therapy in this way allows for the termination of therapy, relapse prevention and booster sessions to be planned in advance, and obstacles to be confronted and overcome. The structure of therapy will also be determined by the particular problem with which the client presents. For example, if a client is diagnosed in accordance with the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) of the American Psychiatric Association (APA, 2013) as having a particular disorder, the structure indicated in Chapter 10 (Treatment Protocols) may be followed.

5 Goal-directed therapy

We have already described the way in which the therapist and client collaboratively work together. When the client brings material to the session, the therapist encourages her to put this into behavioural terms. For example, if the client says that she feels depressed, the therapist will check out with her how this depression manifests itself in her. If she says, among other aspects, that she now seldom socializes, that she no longer keeps a healthy diet or that she has abandoned activities that she previously found enjoyable, the re-establishment of these tasks may become specific goals for therapy. Similarly, anyone who seeks therapy seeks change in some way: the therapist will work collaboratively with the client to decide on the changes which are germane to therapy. Goals will be decided upon collaboratively, together with the tasks necessary to bring about such goals. There may be occasions when the client initially wants to achieve a goal which is counter-productive to her progress; for example, where she seeks goals consistent with the unrealistic belief that she must be perfect in every way. In such cases, the therapist will discuss this frankly with her. It is only through appropriate goal setting that brief therapy is possible. Realistically, brief cognitive behaviour therapy is 'limited goal therapy' (see Lazarus and Fay, 1990) and if a client has many therapeutic goals then he or she may be unsuited to a brief intervention.

6 Examines and questions unhelpful thinking

The cornerstone of cognitive behaviour therapy is that thoughts guide behaviour, emotions and (in some cases) physiological responses. A person will need to alter their thinking if they are to overcome various psychological problems. Depending on the nature of the problem, this may entail working on automatic thoughts, intermediate thoughts or core beliefs. Unlike some forms of cognitive therapy such as rational emotive behaviour therapy – REBT (Ellis, 1994), cognitive behaviour therapy does not confront unhelpful thinking head on, but uses a process of socratic questioning whereby the client is encouraged to look at the evidence for holding his unhelpful (unrealistic or negative) beliefs (Beck et al., 1979: 66–71). It is important to check out the meaning of a client's beliefs before attempting to work on them. This becomes particularly important when working across cultures (Ruddell, 1997: 22–4). Another major difference between rational emotive behaviour therapy and cognitive behaviour therapy is that the

latter works mainly at an inferential level during the beginning stage of therapy, while REBT works mostly at an evaluative level. For example, consider the person mentioned when we viewed catastrophizing (p. 11). The successful manager drew the inference that she would ‘make a mess’ of her presentation. The cognitive behaviour therapist may invite her to look at the evidence for this inference; if the evidence were lacking, this would remove the foundations on which her other beliefs (about letting her company down, losing her job and becoming destitute) are founded. However, the rational emotive behaviour therapist would prefer to focus on the evaluations which may ensue from such an inference such as ‘I must not make a mess of the presentation, and if I did, I couldn’t stand it’.

A list of questions about thoughts and beliefs from which the therapist may draw has been developed by Palmer and Dryden (1995) and Palmer and Strickland (1996). They are reproduced in Figure 2.6 and are best used in the context of the process of cognitive behaviour therapy outlined throughout this book. These questions are also given in Appendix 1 as a *self-help aid*, which the client may use themselves.

- Is it logical?
- Would a scientist agree with your logic?
- Where is the evidence for your belief?
- Where is the belief written (apart from inside your own head!)?
- Is your belief realistic?
- Would your friends and colleagues agree with your idea?
- Does everybody share your attitude? If not, why not?
- Are you expecting yourself or others to be perfect as opposed to fallible human beings?
- What makes the situation so terrible, awful or horrible?
- Are you making a mountain out of a molehill?
- Will it seem this bad in one, three, six or 12 months’ time?
- Will it be important in two years’ time?
- Are you exaggerating the importance of this problem?
- Are you fortune telling with little evidence that the worst case scenario will actually happen?
- If you ‘can’t stand it’ or ‘can’t bear it’ what will really happen?
- If you ‘can’t stand it’ will you really fall apart?
- Are you concentrating on your own (or others’) weaknesses and neglecting strengths?
- Are you agonizing about how you think things should be instead of dealing with them as they are?
- Where is this thought or attitude getting you?
- Is your belief helping you to attain your goals?
- Is your belief goal-focused and problem-solving?
- If a friend made a similar mistake, would you be so critical?
- Are you thinking in all or nothing terms: is there any middle ground?
- Are you labelling yourself, somebody or something else? Is this logical and a fair thing to do?
- Just because a problem has occurred does it mean that you/they/it are ‘stupid’, ‘a failure’, ‘useless’ or ‘hopeless’?
- Are you placing rules on yourself or others (e.g. shoulds or musts, etc.)? If so, are they proving helpful and constructive?
- Are you taking things too personally?
- Are you blaming others unfairly just to make yourself (temporarily) feel better?

Figure 2.6 Questions to help examine unhelpful thinking

7 *Uses range of aids and techniques*

We have already noted that a central task of the cognitive behaviour therapist is to arrive at a cognitive conceptualization of the client's problems. The conceptualization, which may be developed over time, guides the course of therapy. This leaves the therapist reasonably free to import a range of techniques and aids to help bring about a change in the client's unhelpful thinking, which will in turn lead to the client overcoming his emotional and behavioural problems. However, any such techniques and aids are firmly embedded within the framework and principles of cognitive behaviour therapy rather than being 'add ons'. An example of a technique is the use of behavioural experiments with panic disordered clients, such as voluntary hyperventilation (Clark, 1986). Aids include a wide range of instruments – questionnaires – (see Ruddell, 1997) to measure aspects of a client's problem, such as Rapid Assessment Instruments (RAIs; see Corcoran and Fischer, 1987). Probably the most commonly used aid in cognitive behaviour therapy is the Beck Depression Inventory (BDI; Beck et al., 1961; Beck and Steer, 1987). Another aid is the *automatic thought form*, of which there are many variations. Our own form (completed) is shown in Figure 2.7 and discussed previously (p. 10). A blank version is shown as Appendix 2.

8 *Teaches client to become own therapist*

One of the main reasons cognitive behaviour therapy is open, structured, collaborative, relatively brief, goal directed and uses homework is to hand over the process of bringing about change to the client before therapy is terminated. The scope and fluency of the skills the client learns will depend in part on the nature and severity of the client's problem, which in turn will influence the length of therapy. A crucial factor in the client becoming his own therapist is his active participation in the process of therapy within formal sessions as well as in assignments outside them.

9 *Homework setting*

The average length of a therapeutic session is about one hour. If a client only focuses on his problems during the session, this means that within a week 167 hours will not be put to good therapeutic use. In turn, this leads to a lack of continuity in working with a particular problem because the therapeutic process of recording, monitoring and assessing thoughts will not be easily carried into daily living. A useful analogy here is that of maintaining physical health: people do not usually object to cleaning their teeth, bathing, washing their hair regularly and so on – in just the same way it is important to allot time to maintaining our mental health. A problem sometimes encountered with the setting of 'homework' is the word itself. Some people connect it with schoolwork, which in turn may have negative associations. It is important to check this out with a client and if this is the only obstacle, to use a term, preferably chosen by him, which does not have such negative connotations. 'Assignment' is a commonly used alternative. In passing, such thoughts can be used as therapeutic material. A further reason for clients to continue their work outside sessions is that it is sometimes not until they are in the midst of a particular situation, or type of situation, that they are able to capture their most salient automatic thoughts, sometimes known as 'hot cognitions'. Another important reason for homework is that it more ably equips the client with the means to continue therapy alone once the sessions come to an end, since he will already have developed a degree of proficiency from

What happened? This might be an event, thought, image or memory you had
Watching TV - Programme about marriage

What thought or thoughts went through your mind? Rate how much you believe each thought.

(a) *I'll screw this relationship up like the others* 90 %

(b) *I feel I'm useless* 85 %

(c) %

(d) %

What emotions did you feel? How strong was each?

(a) *Anxiety* 65 %

(b) *Depression* 70 %

(c) %

(d) %

Tick the thinking errors for each thought

	a	b	c	d
All or nothing thinking		✓		
Personalization/blame		✓		
Catastrophizing	✓			
Emotional reasoning		✓		
'Should' or 'must' statements				
Mental filter				
Discounting the positive	✓	✓		
Over-generalization	✓			
Magnification/minimization				
Labelling		✓		
Jumping to conclusions – mind reading				
Fortune telling		✓		

Alternative view for each thought	Rate	Alternative view for each thought	Rate
(a) <i>I'm doing something about it by having counselling. Some parts of relationship are okay and Kas really likes me</i>	80 %	(b) <i>I know in my heart of hearts I'm not really useless</i>	85 %
(c) %		(d) %	

Rate emotions now

(a) <i>Anxious</i>	20 %	(b) <i>Depressed</i>	30 %
(c) %		(d) %	

Figure 2.7 Automatic thought form

carrying out homework assignments. Assignments vary enormously, depending on the client, the problem and the stage of therapy. A common assignment is to complete an automatic thought form (see Figure 2.7).

10 Time limited

Time constraints have been more fully discussed in Chapter 1 in relation to brief cognitive behaviour therapy. We wish only to add here that cognitive behaviour therapy is limited in time, compared to many other approaches, due to its directive, collaborative, goal directed and structured approach.

11 Audio recording sessions

The practice of audio recording sessions is not central to cognitive behaviour therapy but it is often carried out and can be useful for the following reasons. First, it can be helpful for supervision and may provide the supervisor with different and more detailed primary information about the session than the secondary description given by the (trainee) therapist possibly after some time has elapsed. As with other aspects of cognitive behaviour therapy, audio recording is carried out with the collaboration of the client, alongside a discussion of the reasons for use of a digital recorder. Second, the client may benefit from recording the session himself as it enables him to revisit aspects of the session at home. This reinforces the practice of working therapeutically both inside and outside the session (see ‘Homework setting’ above), contributes to the openness of therapy (see ‘Collaborative relationship’ above) and helps enable clients to develop therapeutic skills which they can apply to their own problems (see ‘Teaches client to become own therapist’ above). If the client decides to make an audio recording of the session on their cell/mobile phone or smart phone, it is important that they are made aware of the lack of security of digital recordings and files using phones. With young people, in particular, the intentional sharing of digital audio files with friends or family may have unintended consequences now or in the future especially if the files are uploaded to the internet or shared.

The following extract is taken from a typical session. The dialogue will be interrupted with commentary indicating the points at which the factors above, *the fundamental characteristics of cognitive behaviour therapy*, are demonstrated. The therapist and client have already greeted each other and both have set their audio tapes in motion for the session.

Therapist: How have you been feeling this week, Tom?

Client: It’s not been so bad the last couple of days, but at the weekend, I went right down again – back to square one.

Therapist: So it seems like your mood has been quite up and down . . .

Client: Hmm.

Therapist: Can we put that on the agenda to look at in more detail?

Client: Yeah.

Even from this brief extract, taken from the start of a session, some of the characteristics of cognitive behaviour therapy are in evidence. The therapist commences by checking the client’s mood and will shortly move on briefly to review the client’s week. These are the first components in the structure of a typical session as discussed in the fourth fundamental characteristic, ‘Structure to sessions and to therapy’ (see above). It is also apparent that the therapist is interacting with the client and demonstrates the directive

quality of his therapeutic style by focusing on agenda setting (see ‘Therapeutic style’ above). However, the therapist tempers this directive aspect by eliciting feedback from the client, which helps in establishing a ‘Collaborative relationship’ (see above).

Therapist: Could I see your depression inventory? [*Client hands therapist a Beck Depression Inventory (BDI) completed prior to the session.*]

Therapist: Thanks... Is there anything else that happened during the week that you would like to talk about today?

Client: The weekend was awful. Kas started on at me and things went from bad to worse...

Therapist: Okay. We’ve put what happened at the weekend on the agenda. Before we set the rest of the agenda, I’d briefly like to ask you about last week’s session – what stands out in your mind about it?

Client: Well, it was a relief to find out that I can do something about my problems after all this time and that they’re all connected. In a way, that made it seem more manageable. Also, the forms you gave me helped me to see that the way I think about things can make my problems worse, so if I start to think about things in a different way I could start to feel better. It was helpful to have this jotted in my notebook as a reminder.

The therapist regularly monitors the client’s mood throughout the course of therapy as well as within individual sessions. As noted under item 7 above, ‘Uses range of aids and techniques’, the therapist commonly uses the Beck Depression Inventory (BDI) to monitor the client’s mood. Many therapists arrange for the client to complete appropriate inventories in the waiting area immediately prior to commencing a session, as the therapist in the extract above demonstrates. The client also alludes to two aids: a therapy notebook and an automatic thought form (see Figure 2.7). In brief cognitive behaviour therapy, clients are encouraged to keep a therapy notebook in which salient details of the session are noted as well as points outside the session which the client believes are important. An important aspect of the therapy notebook is to link the sessions together and to link therapy with other parts of the client’s life. The automatic thought form was used by Tom as part of an assignment following the last session (see item 9 ‘Homework setting’). Although the client in this extract says that the forms helped him to link his thoughts and feelings together, this was a theme already discussed in some detail when the client’s problems were initially formulated (see item 2 ‘Formulation of problem’) and initial goals for therapy set (see item 5 ‘Goal-directed therapy’). The client’s ‘insight’ of linking thoughts and feelings as a result of working with automatic thought forms outside the session is one of the benefits of the psychoeducational approach adopted by cognitive behaviour therapy. This is also an early stage in the development of the client learning to work independently of the therapist (see item 8 ‘Teaches client to become own therapist’). Throughout therapy, the therapist focuses not only on what the client wishes to change, or their difficulties, but recognizes and focuses on the client’s strengths and how these can be integrated into the process of therapeutic change (see Kuyken et al., 2009; Mooney and Padesky, 2002). The extract also sees the therapist following a typical session structure by moving on to set an agenda (see item 4 ‘Structure to sessions and to therapy’).

- Therapist:* I'm glad you've been so quick to make the link between thoughts and feelings. That's a really important part of this work... Did you find anything in the last session that troubled you?
- Client:* No, not once I got here!
- Therapist:* [laughs] Is there anything else that happened during the week that you would like to include on today's agenda?
- Client:* No, I don't think so.
- Therapist:* Right. And is there anything else you would like to put on today's agenda?
- Client:* No... Only what we said I'd try out during the week. I didn't manage to do it all.
- Therapist:* Okay, shall we put last week's homework on the agenda too, and spend some time looking at the difficulties you had in completing it?
- Client:* Yeah, okay.
- Therapist:* You might remember me saying that we will usually look at the work you've done outside of the sessions, with me during the session?
- Client:* That's right.
- Therapist:* That's most of our agenda set for today. Do you recall what else we usually have on the agenda too?
- Client:* I suppose we need some time to look at things I can do ... like the forms I did last week...
- Therapist:* Your assignment?
- Client:* Yeah, that's it.
- Therapist:* Okay, and we can allocate some time to set the coming week's assignments and can finish by looking at your thoughts and feelings about this session. Can we move straight on to look at your assignments? You said that you hadn't been able to complete it all.
- Client:* That's right. I did three of the sheets before the weekend, but after our big row I felt really down and didn't feel up to doing any more.
- Therapist:* You said earlier that the forms you took away with you were helpful in letting you make a link between the feelings you had and the thoughts that triggered them and I'd like to carry that forward to how your thoughts and feelings about your row with Kas led to you being unable to carry on with the work you had started and had found helpful up to that point... Do you want to look at the work you have done first, or would you prefer to focus on the difficulties you had that prevented you from doing the rest?
- Client:* Well, after we had the row, it was like all the stuff I'd done up to that point got wiped out ... and it made the work with the forms seem meaningless. So I guess I'd like to look at that part first.
- Therapist:* Okay. You said the work you had done up to that point had got 'wiped out' and you also said earlier that you had completed three of the automatic

thought forms. Can I check this out with you? Would you think of a time shortly before you had the row with Kas... Can you let me know whether or not the work with the forms was useful up to that point?

Client: Yeah, as I said earlier, I did find it helpful linking the thoughts and feelings and was feeling quite optimistic but when we had the row it just counted for nothing.

Therapist: When you were using the forms, part of your assignment was to identify disturbing feelings and link these with particular thoughts. Do you recall if the form asked you to identify anything else?

Client: [*looking at homework*] What, the alternative thoughts?

Therapist: It's one of the sections on the form between your automatic thoughts and your alternative thoughts!

Client: Oh, you mean the thinking errors.

Therapist: Yes! That's it! Now you said that the work had been useful up to the row, but then its usefulness had been 'wiped out' by the row. Can you identify any thinking errors here?

Client: Well, I suppose I was over-generalizing.

Therapist: Can you expand on that for me?

Client: Well, because we had a big row, and that was really dreadful, it doesn't mean that everything else going on for me has to be affected and it doesn't turn something that seemed helpful at the time into uselessness.

Therapist: How much do you believe that, Tom?

Client: Well, as I'm saying it to you now, I believe it a lot and it makes sense, but at the time, I just felt on a 'downer' and couldn't think of anything else except how dreadful it all was.

Therapist: Okay. Let me just feed that back to you. You said that when you had an argument with Kas, everything was 'wiped out'. Then looking back at the incident, you recognized that the row – although very disturbing to you at the time – didn't alter the usefulness of your new way of looking at your problems... If you had another similar row this week, do you think you would be able to view it in this new way?

Client: [*long pause while client looks away*] It's like I have two heads. There's the one I have as I sit here with you, and also as I'm filling out the forms, where I can look at things in a new light. But there's the one that's always been there, and can't bring in these new ways of thinking, when I'm right in the middle of a situation.

Therapist: That's a very good point you've made. I think it is important for me to emphasize that we have only had a couple of sessions and that it will take time and practice to use the new skills you are developing in the heat of the moment. It is partly for this reason that I ask you to write out your difficulties and alternative responses on the forms so that you can gradually incorporate your new ways of thinking and feeling into your everyday life.

In this extract, the therapist and client continue to work through a typically structured session and proceed to discuss agenda items. The therapist assists the client to *examine and question unhelpful thinking* (item 6), which includes identifying *thinking errors*. The therapist decided not to question the client's thinking errors of magnification or catastrophizing when he used the word 'dreadful' to describe an event. He made a mental note of this for later discussion and also led the client towards identifying and challenging a number of other thinking errors surrounding this one event. In this way, the therapist continues to socialize the client into cognitive behaviour therapy. This is aided by helping the client to recognize the importance of work outside of the sessions (see item 8 'Teaches client to become own therapist') and also by helping the client to appreciate that it is unhelpful to view therapeutic change in all or nothing terms (see 'Thinking errors', p. 10). The client's 'two heads' will only become one as he practises and assimilates new skills enabling him to bring new thinking patterns to current difficulties.

It is an accreditation and good practice requirement that every practitioner receive regular, high-quality professional supervision from an experienced CBT therapist to maintain quality standards and to protect the client.

The present chapter has focused on the fundamental aspects of cognitive behaviour therapy and has concluded with annotated extracts which help to exemplify them while giving a flavour of cognitive behaviour therapy in practice. In the following chapters we consider the process in greater detail.

Practice points

- 1 Learn the cognitive model and use it daily in your own life to help you to understand it. Beliefs are learned and can be changed.
- 2 Use the ABC to help you to remember:
 - A = Activating event (event, image, thought, memory, etc.).
 - B = Belief (automatic thoughts and underlying beliefs).
 - C = Consequences (emotions, behaviour, physiology and further thoughts).
- 3 Recognize that thinking errors are central to the cognitive model: know them thoroughly.
- 4 Use basic counselling skills as a foundation for your practice of cognitive behaviour therapy.
- 5 Structure the therapy session by negotiating an agenda.
- 6 Familiarize yourself with the fundamental characteristics of cognitive behaviour therapy.
- 7 Remind yourself and your client of the importance of the other 167 hours outside of the therapy session every week to put cognitive behaviour therapy into practice in the real world.
- 8 Arrange for appropriate supervision.
- 9 With the client's permission make a recording of the session for the purposes of supervision and encourage the client to record the session too and listen to it as an in-between therapy session exercise.