A Brief Introduction To

Cognitive-Behaviour Therapy

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Cognitive-Behaviour Therapy (CBT) is based on the concept that emotions and behaviours result (primarily, though not exclusively) from cognitive processes; and that it is possible for human beings to modify such processes to achieve different ways of feeling and behaving. There are a number of 'cognitive-behavioural' therapies, which, although developed separately, have many similarities.

Some history

The 'cognitive' psychotherapies can be said to have begun with Alfred Adler, one of Freud's inner circle. Adler disagreed with Freud's idea that the cause of human emotionality was 'unconscious conflicts', arguing that thinking was a more significant factor.

Cognitive Behaviour Therapy has its modern origins in the mid 1950's with the work of Albert Ellis, a clinical psychologist. Ellis originally trained in psychoanalysis, but became disillusioned with the slow progress of his clients. He observed that they tended to get better when they changed their ways of thinking about themselves, their problems, and the world. Ellis reasoned that therapy would progress faster if the focus was directly on the client's beliefs, and developed a method now known as *Rational Emotive Behaviour Therapy* (REBT). Ellis' method and a few others, for example Glasser's 'Reality Therapy' and Berne's 'Transactional Analysis', were initially categorised under the heading of 'Cognitive Psychotherapies'.

The second major cognitive psychotherapy was developed in the 1960's by psychiatrist Aaron Beck; who, like Ellis, was previously a psychoanalyst. Beck called his approach *Cognitive Therapy* (CT). (Note that because the term 'Cognitive Therapy' is also used to refer to the *category* of cognitive therapies, which includes REBT and other approaches, it is sometimes necessary to check whether the user is alluding to the general category or to Beck's specific variation).

Since the pioneering work of Ellis and Beck, a number of other cognitive approaches have developed, many as offshoots of REBT or CT. The term 'Cognitive Behaviour Therapy' came into usage around the early 1990's, initially used by behaviourists to describe behaviour therapy with a cognitive flavour. In more recent years, 'CBT' has evolved into a generic term to include the whole range of cognitively-oriented psychotherapies. REBT and CT have been joined by such developments as Rational Behaviour Therapy (Maxie Maultsby), Multimodal Therapy (Arnold Lazarus), Dialectical Behaviour Therapy (Marsha Linehan), Schema Therapy (Jeffrey Young) and expanded by the work of such theorists as Ray DiGiuseppe, Michael Mahoney, Donald Meichenbaum, Paul Salkovskis and many others.

All of these approaches are characterised by their view that cognition is a key determining factor in how human beings feel and behave, and that modifying cognition through the use of cognitive and behavioural techniques can lead to productive change in dysfunctional emotions and behaviours.

By now it will be seen that 'CBT' is a generic term that encompasses not one but a number of approaches. When reading articles or texts on CBT, it is helpful to identify the theoretical perspective involved. Often they are saying the same thing, but using different words. Being aware of the terminological differences will help the reader understand and, hopefully, integrate the various approaches. This article will present an approach that combines REBT and CT, incorporating elements of some other approaches as well.

Theory of causation

CBT is not just a set of techniques – it also contains comprehensive theories of human behaviour.

CBT proposes a 'biopsychosocial' explanation as to how human beings come to feel and act as they do – i.e. that a combination of biological, psychological, and social factors are involved.

The most basic premise is that almost all human emotions and behaviours are the result of what people think, assume or believe (about themselves, other people, and the world in general). It is

what people believe about situations they face – not the situations themselves – that determines how they feel and behave.

Both REBT & CT, however, argue that a person's biology also affects their feelings and behaviours – an important point, as it is a reminder to the therapist that there are some limitations on how far a person can change.

A useful way to illustrate the role of cognition is with the 'ABC' model. (originally developed by Albert Ellis, the ABC model has been adapted for more general CBT use). In this framework 'A' represents an event or experience, 'B' represents the beliefs about the A, and 'C' represents the emotions and behaviours that follow from those beliefs.

Here is an example of an 'emotional episode', as experienced by a person prone to depression who tends to misinterpret the actions of other people:

A. *Activating event:*
    Friend passed me in the street without acknowledging me.

B. *Beliefs* about A:
    He's ignoring me. He doesn't like me.
    I'm unacceptable as a friend – so I must be worthless as a person.
    For me to be happy and feel worthwhile, people must like me.

C. *Consequence:*
    Emotions: hurt, depressed.
    Behaviours: avoiding people generally.

Note that 'A' doesn't cause 'C': 'A' triggers off 'B'; 'B' then causes 'C'. Also, ABC episodes do not stand alone: they run in chains, with a 'C' often becoming the 'A' of another episode – we observe our own emotions and behaviours, and react to them. For instance, the person in the example above could observe their avoidance of other people ('A'), interpret this as weak ('B'), and engage in self-downing ('C').

Note, too, that most beliefs are outside conscious awareness. They are habitual or automatic, often consisting of underlying 'rules' about how the world and life should be. With practice, though, people can learn to uncover such subconscious beliefs.

What is dysfunctional thinking?

We have seen that what people think determines how they feel. But what *types* of thinking are problematical for human beings?

A definition
To describe a belief as 'irrational' is to say that:

1. It blocks a person from achieving their goals, creates extreme emotions that persist and which distress and immobilise, and leads to behaviours that harm oneself, others, and one's life in general.

2. It distorts reality (it is a misinterpretation of what is happening and is not supported by the available evidence);

3. It contains illogical ways of evaluating oneself, others, and the world.

The Three Levels of Thinking
Human beings appear to think at three levels: (1) Inferences; (2) Evaluations; and (3) Core beliefs.

Every individual has a set of general 'core beliefs' – usually subconscious – that determines how they react to life. When an event triggers off a train of thought, what someone *consciously* thinks depends on the core beliefs they *subconsciously* apply to the event.

Let's say that a person holds the *core belief*: 'For me to be happy, my life must be safe and predictable.' Such a belief will lead them to be hypersensitive to any possibility of danger and overestimate the likelihood of things going wrong. Suppose they hear a noise in the night. Their hypersensitivity to danger leads them to *infer* that there is an intruder in the house. They then *evaluate* this possibility as catastrophic and unbearable, which creates feelings of panic.

Here is an example (using the ABC model) to show how it all works:

A. Your neighbour phones and asks if you will baby-sit for the rest of the day. You had already planned to catch up with some gardening.

B. You *infer* that: 'If I say no, she will think badly of me.'
    You *evaluate* your inference: 'I couldn't stand to have her disapprove of me and see me as selfish.'
    Your inference and the evaluation that follows are the result of holding the *underlying core belief:* 'To feel OK about myself, I need to be liked, so I must avoid disapproval from any source.'

C. You feel anxious and say yes.

In summary, people view themselves and the world around them at three levels: (1) inferences, (2) evaluations, and (3) core beliefs. The therapist's main objective is to deal with the underlying, semi-permanent, general 'core beliefs' that are the continuing cause of the client's unwanted reactions.

CT focuses mainly on inferential-type thinking, helping the client to check out the reality of their beliefs, and has some sophisticated techniques to achieve this empirical aim.

REBT emphasises dealing with evaluative-type thinking (in fact, in REBT, the client's inferences are regarded as part of the 'A' rather than the 'B'). When helping clients explore their thinking, REBT practitioners would tend to use strategies that examine the logic behind beliefs (rather than query their empirical validity).

What REBT and CT do share, though, is an ultimate concern with underlying core beliefs.

Two Types of Disturbance

Knowing that there are different levels of thinking does not tell us much about the actual *content* of that thinking. The various types of CBT have different ideas of what content is important to focus on (though the differences are sometimes a matter of terminology more than anything else).

One way of looking at the content issue that I find helpful comes from REBT, which suggests that human beings defeat or 'disturb' themselves in two main ways: (1) by holding irrational beliefs about their 'self' (*ego* disturbance) or (2) by holding irrational beliefs about their emotional or physical comfort (*discomfort* disturbance). Frequently, the two go together – people may think irrationally about both their 'selves' and their circumstances – though one or the other will usually be predominant.

Seven inferential distortions

In everyday life, events and circumstances trigger off two levels of thinking: inferring and evaluating. At the first level, we make guesses or *inferences* about what is 'going on' – what we think has happened, is happening, or will be happening. Inferences are statements of 'fact' (or at least what we think are the facts – they can be true or false). Inferences that are irrational usually consist of 'distortions of reality' like the following:

- *Black and white thinking:* seeing things in extremes, with no middle ground – good or bad, perfect versus useless, success or failure, right against wrong, moral versus immoral, and so on. Also known as *all-or-nothing thinking*.
- *Filtering:* seeing all that is wrong with oneself or the world, while ignoring any positives.
- *Over-generalisation:* building up one thing about oneself or one's circumstances and ending up thinking that it represents the whole situation. For example: 'Everything's going wrong', 'Because of this mistake, I'm a total failure'. Or, similarly, believing that something which has happened once or twice is happening all the time, or that it will be a never-ending pattern: 'I'll always be a failure', 'No-one will ever want to love me', and the like.

- *Mind-reading:* making guesses about what other people are thinking, such as: 'She ignored me on purpose', or 'He's mad with me'.
- *Fortune-telling:* treating beliefs about the future as though they were actual realities rather than mere predictions, for example: 'I'll be depressed forever', 'Things can only get worse'.
- *Emotional reasoning:* thinking that because we *feel* a certain way, this is how it really is: 'I feel like a failure, so I must be one', 'If I'm angry, you must have done something to make me so', and the like.
- *Personalising:* assuming, without evidence, that one is responsible for things that happen: 'I caused the team to fail', 'It must have been me that made her feel bad', and so on.

The seven types of inferential thinking described above have been outlined by Aaron Beck and his associates (see, for example: Burns, 1980).

Evaluations

As well as making inferences about things that happen, we go beyond the 'facts' to *evaluate* them in terms of what they *mean to us*. Evaluations are sometimes conscious, sometimes beneath awareness. According to REBT, irrational evaluations consist of one or more of the following four types:

- *Demandingness.* Described colourfully by Ellis as 'musturbation', demandingness refers to the way people use unconditional shoulds and absolutistic musts – believing that certain things must or must not happen, and that certain conditions (for example success, love, or approval) are absolute necessities. Demandingness implies certain 'Laws of the Universe' that must be adhered to. Demands can be directed either toward oneself or others. Some REBT theorists see demandingness as the 'core' type of irrational thinking, suggesting that the other three types derive from it
- *Awfulising.* Exaggerating the consequences of past, present or future events; seeing something as awful, terrible, horrible – the worst that could happen.
- *Discomfort intolerance* (often referred to as *'can't-stand-it-itis')*. This is based on the idea that one cannot bear some circumstance or event. It often follows awfulising, and leads to demands that certain things not happen.
- *People-Rating.* People-rating refers to the process of evaluating one's entire self (or someone else's). In other words, trying to determine the total value of a person or judging their worth. It represents an overgeneralisation. The person evaluates a specific trait, behaviour or action

according to some standard of desirability or worth. Then they apply the evaluation to their total person – eg. 'I did a bad thing, therefore I am a bad person.' People-rating can lead to reactions like self-downing, depression, defensiveness, grandiosity, hostility, or overconcern with approval and disapproval.

Core beliefs

Guiding a person's inferences and evaluations are their *core beliefs*. Core beliefs are the underlying, general assumptions and rules that guide how people react to events and circumstances in their lives. They are referred to in the CBT literature by various names: 'schema'; 'general rules'; 'major beliefs'; 'underlying philosophy', etc. REBT and CT both propose slightly different types of core belief. I find it convenient to refer to them as (1) *assumptions* and (2) *rules*.

Assumptions are a person's beliefs about how the world is – how it works, what to watch out for, etc. They reflect the 'inferential' type of thinking. Here are some examples:

- My unhappiness is caused by things that are outside my control – so there is little I can do to feel any better.
- Events in my past are the cause of my problems – and they continue to influence my feelings and behaviours now.
- It is easier to avoid rather than face responsibilities.

Rules are more prescriptive – they go beyond describing what *is* to emphasise what *should be*. They are 'evaluative' rather than inferential. Here are some examples:

- I need love and approval from those significant to me – and I must avoid disapproval from any source.
- To be worthwhile as a person I must achieve, succeed at whatever I do, and make no mistakes.
- People should always do the right thing. When they behave obnoxiously, unfairly or selfishly, they must be blamed and punished.
- Things must be the way I want them to be, otherwise life will be unbearable.
- I must worry about things that could be dangerous, unpleasant or frightening – otherwise they might happen.
- Because they are too much to bear, I must avoid life's difficulties, unpleasantness, and responsibilities.
- Everyone needs to depend on someone stronger than themselves.

- I should become upset when other people have problems, and feel unhappy when they're sad.
- I shouldn't have to feel discomfort and pain – I can't stand them and must avoid them at all costs.
- Every problem should have an ideal solution – and it's intolerable when one can't be found.

Helping people change

The steps involved in helping clients change can be broadly summarised as follows:

1. *Help the client understand that emotions and behaviours are caused by beliefs and thinking*. This may consist of a brief explanation followed by assignment of some reading.

2. *Show how the relevant beliefs may be uncovered*. The ABC format is useful here. Using an episode from the client's own recent experience, the therapist notes the 'C', then the 'A'. The client is asked to consider (at 'B'): 'What was I telling myself about 'A', to feel and behave the way I did at 'C'? As the client develops understanding of the nature of irrational thinking, this process of 'filling in the gap' will become easier. Such education may be achieved by reading, direct explanation, and by record-keeping with the therapist's help and as homework between sessions.

3. *Teach the client how to dispute and change the irrational beliefs*, replacing them with more rational alternatives. Again, education will aid the client. The ABC format is extended to include 'D' (*Disputing* irrational beliefs), 'E' (the desired new *Effect* – new ways of feeling and behaving), and 'F' (*Further Action* for the client to take).

4. *Help the client to get into action*. Acting against irrational beliefs is an essential component of CBT. The client may, for example, dispute the belief that disapproval is intolerable by deliberately doing something to attract it, to discover that they in fact survive. CBT's emphasis on both rethinking and action makes it a powerful tool for change. The action part is often carried out by the client as 'homework'.

The process of CBT therapy

What follows is a summary of the main components of an CBT intervention.

Engage client

The first step is to build a relationship with the client. This can be achieved using the core conditions of empathy, warmth and respect.

Watch for any 'secondary disturbances' about coming for help: self-downing over having the problem or needing assistance; and anxiety about coming to the interview.

Finally, possibly the best way to engage a client is to demonstrate to them at an early stage that change is possible and that CBT is able to assist them to achieve this goal.

Assess the problem, person, and situation

Assessment will vary from person to person, but following are some of the most common areas that will be assessed as part of an CBT intervention.

- Start with the client's view of what is wrong for them.
- Determine the presence of any related clinical disorders.
- Obtain a personal and social history.
- Assess the severity of the problem.
- Note any relevant personality factors.
- Check for any secondary disturbance: How does the client feel about having this problem?
- Check for any non-psychological causative factors: physical conditions; medications; substance abuse; lifestyle/environmental factors.

Prepare the client for therapy

- Clarify treatment goals.
- Assess the client's motivation to change.
- Introduce the basics of CBT, including the biopsychosocial model of causation.
- Discuss approaches to be used and implications of treatment.
- Develop a contract.

Implement the treatment programme

Most of the sessions will occur in the implementation phase, using activities like the following:

- Analysing specific episodes where the target problems occur, ascertaining the beliefs involved, changing them, and developing relevant homework (known as 'thought recording' or 'rational analysis').
- Developing behavioural assignments to reduce fears or modify ways of behaving.
- Supplementary strategies & techniques as appropriate, e.g. relaxation training, interpersonal skills training, etc.

Evaluate progress

Toward the end of the intervention it will be important to check whether improvements are due to significant changes in the client's thinking, or simply to a fortuitous improvement in their external circumstances.

Prepare the client for termination

It is usually very important to prepare the client to cope with setbacks. Many people, after a period of wellness, think they are 'cured' for life. Then, when they slip back and discover their old problems are still present to some degree, they tend to despair and are tempted to give up self-help work altogether.

- Warn that relapse is likely for many mental health problems and ensure the client knows what to do when their symptoms return.
- Discuss their views on asking for help if needed in the future. Deal with any irrational beliefs about coming back, like: 'I should be cured for ever', or: 'The therapist would think I was a failure if I came back for more help'.

The practice principles of CBT

- The basic aim of CBT is to leave clients at the completion of therapy with freedom to choose their emotions, behaviours and lifestyle (within physical, social and economic restraints); and with a method of self-observation and personal change that will help them maintain their gains.
- Not all unpleasant emotions are seen as dysfunctional. Nor are all pleasant emotions functional. CBT aims not at 'positive thinking'; but rather at realistic thoughts, emotions and behaviours that are in proportion to the events and circumstances an individual experiences.
- Developing emotional control does not mean that people are encouraged to become limited in what they feel – quite the opposite. Learning to use cognitive-behavioural strategies helps oneself become open to a wider range of emotions and experiences that in the past they may have been blocked from experiencing.
- There is no 'one way' to practice CBT. It is 'selectively eclectic'. Though it has techniques of its own, it also borrows from other approaches and allows practitioners to use their imagination. There are some basic assumptions and principles, but otherwise it can be varied to suit one's own style and client group.
- CBT is educative and collaborative. Clients learn the therapy and how to use it on themselves (rather than have it 'done to them'). The therapist provides the training – the client carries it out. There are no hidden agendas – all procedures are clearly explained to the client. Therapist and client together design homework assignments.
- The relationship between therapist and client is seen as important, the therapist showing empathy, unconditional acceptance, and encouragement toward the client. In CBT, the relationship exists to *facilitate* therapeutic work – rather than being the therapy itself. Consequently, the therapist is careful to avoid activities that create dependency or strengthen any 'needs' for approval.

- CBT is brief and time-limited. It commonly involves five to thirty sessions over one to eighteen months. The pace of therapy is brisk. A minimum of time is spent on acquiring background and historical information: it is task-oriented and focuses on problem-solving in the present.
- CBT tends to be anti-moralistic and scientific. Behaviour is viewed as functional or dysfunctional, rather than as good or evil. CBT is based on research and the principles of logic and empiricism, and encourages scientific rather than 'magical' ways of thinking.

Finally, the emphasis is on profound and lasting change in the underlying belief system of the client, rather than simply eliminating the presenting symptoms. The client is left with self-help techniques that enable coping in the long-term future.

A typical CBT interview format

What happens in a typical CBT interview? Here is how a typical interview would progress:

1. Review the previous session's homework. Reinforce gains and learning. If not completed, help the client identify and deal with the blocks involved.
2. Establish the target problem to work on in this session.
3. Assess the emotion and/or behaviour: specifically what did the client feel and/or do?
4. Identify the thinking that lead to the unwanted emotions or behaviours.
5. Help the client check out the evidence for and/or logic behind their thinking, preferably using 'Socratic questioning' ('What evidence are you using ... ?' 'How is it true that ... ?' etc. Replace beliefs that are agreed to be dysfunctional.
6. Plan homework assignments to enable the client to put new functional beliefs into practice.

Techniques Used In CBT

There are no techniques that are essential to CBT – one uses whatever works, assuming that the strategy is compatible with CBT theory (the 'selectively eclectic' approach). However, the following are examples of procedures in common use.

Cognitive techniques

- *Rational analysis:* analyses of specific episodes to teach client how to uncover and dispute irrational beliefs (as described above). These are usually done in-session at first – as the client gets the idea, they can be done as homework. (There is an example at the end of this article).

- *Double-standard dispute:* If the client is holding a 'should' or is self-downing about their behaviour, ask whether they would globally rate another person (e.g. best friend, therapist, etc.) for doing the same thing, or recommend that person hold their demanding core belief. When they say 'No', help them see that they are holding a double-standard. This is especially useful with resistant beliefs which the client finds hard to give up.

- *Catastrophe scale:* this is a useful technique to get awfulising into perspective. On a whiteboard or sheet of paper, draw a line down one side. Put 100% at the top, 0% at the bottom, and 10% intervals in between. Ask the client to rate whatever it is they are catastrophising about, and insert that item into the chart in the appropriate place. Then, fill in the other levels with items the client thinks apply to those levels. You might, for example, put 0%: 'Having a quiet cup of coffee at home', 20%: 'Having to mow the lawns when the rugby is on television', 70%: being burgled, 90%: being diagnosed with cancer, 100%: being burned alive, and so on. Finally, have the client progressively alter the position of their feared item on the scale, until it is in perspective in relation to the other items.

- *Devil's advocate:* this useful and effective technique (also known as *reverse role-playing*) is designed to get the client arguing against their own dysfunctional belief. The therapist role-plays adopting the client's belief and vigorously argues for it; while the client tries to 'convince' the therapist that the belief is dysfunctional. It is especially useful when the client now sees the irrationality of a belief, but needs help to consolidate that understanding. (NB: as with all techniques, be sure to explain it to the client before using it).

- *Reframing:* another strategy for getting bad events into perspective is to re-evaluate them as 'disappointing', 'concerning', or 'uncomfortable' rather than as 'awful' or 'unbearable'. A variation of reframing is to help the client see that even negative events almost always have a positive side to them, listing all the positives the client can think of (NB: this needs care so that it does not come across as suggesting that a bad experience is really a 'good' one).

Imagery techniques

- *Time projection:* this technique is designed to show that one's life, and the world in general, continue after a feared or unwanted event has come and gone. Ask the client to visualise the

unwanted event occurring, then imagine going forward in time a week, then a month, then six months, then a year, two years, and so on, considering how they will be feeling at each of these points in time. They will thus be able to see that life will go on, even though they may need to make some adjustments.

- *The 'worst-case' technique:* people often try to avoid thinking about worst possible scenarios in case doing so makes them even more anxious. However, it is usually better to help the client identify the worst that could happen. Facing the worst, while *initially* increasing anxiety, usually leads to a longer-term *reduction* because (1) the person discovers that the 'worst' would be bearable if it happened, and (2) realises that as it probably won't happen, the more likely consequences will obviously be even more bearable; or (3) if it did happen, they would in most cases still have some control over how things turn out.

- *The 'blow-up' technique:* this is a variation of 'worst-case' imagery, coupled with the use of humour to provide a vivid and memorable experience for the client. It involves asking the client to imagine whatever it is they fear happening, then blow it up out of all proportion till they cannot help but be amused by it. Laughing at fears helps get them under control.

Behavioural techniques

One of the best ways to check out and modify a belief is to act. Clients can be encouraged to check out the evidence for their fears and to act in ways that disprove them.

- *Exposure:* possibly the most common behavioural strategy used in CBT involves clients entering feared situations they would normally avoid. Such 'exposure' is deliberate, planned and carried out using cognitive and other coping skills. The purposes are to (1) test the validity of one's fears (e.g. that rejection could not be survived); (2) de-awfulise them (by seeing that catastrophe does not ensue); (3) develop confidence in one's ability to cope (by successfully managing one's reactions); and (4) increase tolerance for discomfort (by progressively discovering that it is bearable).

- *Hypothesis testing:* with this variation of exposure, the client (1) writes down what they fear will happen, including the negative consequences they anticipate, then (2) for homework, carries out assignments where they act in the ways they *fear* will lead to these consequences (to see whether they do in fact occur).

- *Risk-taking:* the purpose is to challenge beliefs that certain behaviours are too dangerous to risk, when reason says that while the outcome is not guaranteed they are worth the chance. For example, if the client has trouble with perfectionism or fear of failure, they might start tasks where there is a chance of failing or not matching their expectations. Or a client who fears rejection might talk to an attractive person at a party or ask someone for a date.

- *Stimulus control:* sometimes behaviours become conditioned to particular stimuli; for example, difficulty sleeping can create a connection between being in bed and lying awake; or the relief felt when a person vomits after bingeing on food can lead to a connection between bingeing and vomiting. Stimulus control is designed to lengthen the time between the stimulus and the response, so as to weaken the connection. For example, the person who tends to lie in bed awake would get up if unable to sleep for 20 minutes and stay up till tired. Or the person purging food would increase the time between a binge and the subsequent purging.

- *Paradoxical behaviour:* when a client wishes to change a dysfunctional tendency, encourage them to deliberately behave in a way contradictory to the tendency. Emphasise the importance of not waiting until they 'feel like' doing it: practising the new behaviour – even though it is not spontaneous – will gradually internalise the new habit.

- *Stepping out of character:* is one common type of paradoxical behaviour. For example, a perfectionistic person could deliberately do some things to less than their usual standard; or someone who believes that to care for oneself is 'selfish' could indulge in a personal treat each day for a week.

- *Postponing gratification* is commonly used to combat low frustration-tolerance by deliberately delaying smoking, eating sweets, using alcohol, sexual activity, etc.

Other strategies

- Skills training, e.g. relaxation, social skills.
- Reading (self re-education).
- Tape recording of interviews for the client to replay at home.

Probably the most important CBT strategy is *homework*. This includes reading, self-help exercises such as thought recording, and experiential activities. Therapy sessions can be seen as 'training sessions', between which the client tries out and uses what they have learned. At the end of this article there is an example of a homework format

which clients can use to analyse specific episodes where they feel or behave in the ways they are trying to change.

Applications of CBT

CBT has been successfully used to help people with a range of clinical and non-clinical problems, using a variety of modalities. Typical clinical applications include:
- Depression
- Anxiety disorders, including obsessive-compulsive disorder, agoraphobia, specific phobias, generalised anxiety, posttraumatic stress disorder, etc.
- Eating disorders
- Addictions
- Hypochondriasis
- Sexual dysfunction
- Anger management
- Impulse control disorders
- Antisocial behaviour
- Jealousy
- Sexual abuse recovery
- Personality disorders
- Adjustment to chronic health problem, physical disability, or mental disorder
- Pain management
- General stress management
- Child or adolescent behaviour disorders
- Relationship and family problems

Modalities

The most common use of CBT is with individual clients, but this is followed closely by group work, for which CBT is eminently suited. CBT is also frequently used with couples, and increasingly with families.

Learning to use CBT

To practise CBT it is important to have a good understanding of dysfunctional thinking. This can be gained by a critical reading of the substantial literature available.

The use of CBT in the interview situation is best learned by attending a training course It can also be observed by reading verbatim records of interviews or from audio or video tapes of interviews conducted by CBT practitioners.

The most effective way you can learn how to help clients uncover and dispute irrational beliefs is to practice CBT on oneself, for example by using written 'self-analysis' exercises (see the last page of this article).

READING LIST

There are many hundreds of books and articles based on CBT. Here is a small selection of what is available.

Self-Help Books

Beck, A. (1988). *Love Is Never Enough*. New York: Harper & Row.

Birkedahl, Nonie. (1990). *The Habit Control Workbook*. Oakland, CA: New Harbinger Publications.

Bourne, Edmund J. (1995). *The Anxiety & Phobia Workbook (Second Edition)*. Oakland, CA: New Harbinger Publications.

Burns, David M. (1980). *Feeling Good: The New Mood Therapy*. New York: Signet, New American Library.

Calabro, Louis E. (1990) *Living with Disability*. New York: Institute for Rational-Emotive Therapy.

Cooper, C.L. & Palmer, S. (2000). *Conquer Your Stress*. London: Chartered Institute of Personnel and Development.

Copeland, Mary Ellen. (1998). *The Worry Control Workbook*. Oakland, CA: New Harbinger Publ.

Davis, Martha. Eshelman, Elizabeth R. & McKay, Matthew. (1988). *The Relaxation and Stress Reduction Workbook*. Oakland, CA: New Harbinger Publ.

Dryden, Windy. (1997). *Overcoming Shame*. London: Sheldon Press.

Dumont, R. (1997). *The Sky Is Falling: Understanding & coping with phobias, panic, and obsessive-compulsive disorders*. New York: Norton.

Ellis, Albert & Abrams, Michael. (1994). *How to Cope With a Fatal Illness: the rational management of death and dying*. New York: Barricade Books, Inc.

Ellis, Albert & Harper, Robert A. (1975). *A New Guide to Rational Living*. Hollywood: Wilshire Book Company.

Ellis, Albert. (1997). *Anger – How to Live With and Without It*. New York: Carol Publishing Group.

Ellis, T.T. & Newman, C.F. (1996). *Choosing to Live: How to defeat suicide through cognitive therapy*. Oakland: New Harbinger Publications.

Fanning, Patrick & McKay, Matthew. (1993). *Being a Man: A guide to the new masculinity,* Oakland, CA: New Harbinger Publications.

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Froggatt, W. (2003). *FearLess: Your guide to overcoming anxiety*. Auckland: HarperCollins

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How to obtain items on this list

Library Interloan

Many of the items listed are available through the interloan system. You can ask your employing organisation's librarian to order them for you, or send a request to your local library.

Purchase

To purchase any of the books:
1. Have a local bookseller order it from overseas.
2. Order via the internet: go to the Centre for Cognitive Behaviour Therapy's website (www.rational.org.nz) and click on 'Book-Shop'.
3. Some of the books, especially those on REBT, can be obtained from the Albert Ellis Institute (www.rebt.org).

CBT on the Internet

There are numerous internet sites related to CBT. A good place to start searching would be the *Centre for Cognitive Behaviour Therapy* website at: http://www.rational.org.nz (as well as viewing articles on that site, go to the 'Links' page for references to other sites).

Rational Self-Analysis

CBT emphasises teaching clients to be their own therapists. A useful technique to aid this is *Rational Self-Analysis* (Froggatt, 2003) which involves writing down an emotional episode in a structured fashion. Here is an example of such an analysis using the case example described earlier:

A. Activating Event (*what started things off)*:

Friend passed me in the street without acknowledging me.

C. Consequence (*how I reacted)*:

Feelings: worthless, depressed. Behaviour: avoiding people generally.

B. Beliefs *(what I thought about the 'A'):*

1. He's ignoring me and doesn't like me. *(inference)*
2. I could end up without friends for ever. *(inference)* This would be terrible. *(evaluation)*
3. I'm not acceptable as a friend *(inference)*- so I must be worthless as a person. *(evaluation)*
4. To feel worthwhile and be happy, I must be liked and approved by everyone significant to me. *(core belief)*

E. New Effect *(how I would prefer to feel/behave):*

Disappointed but not depressed.

D. Disputation *(of old beliefs and developing new rational beliefs to help me achieve the new reaction):*

1. How do I know he ignored me on purpose? He may not have seen me. Even if he did ignore me, this doesn't prove he dislikes me – he may have been in a hurry, or perhaps upset or worried in some way.
2. Even if it were true that he disliked me, this doesn't prove I'll never have friends again. And, even this unlikely possibility would be unpleasant rather than a source of 'terror'.
3. There's no proof I'm not acceptable as a friend. But even if I were, this proves nothing about the total 'me', or my 'worthwhileness'. (And, anyway, what does 'worthwhile' mean?).
4. Love and approval are highly desirable. But, they are not absolute necessities. Making them so is not only illogical, but actually screws me up when I think they may not be forthcoming. Better I keep them as preferences rather than demands.

F. Further Action *(what I'll do to avoid repeating the same irrational/thoughts reactions):*

1. Re-read material on catastrophising and self-rating.
2. Go and see my friend, check out how things really are (at the same time, realistically accepting that I can't be sure of the outcome).
3. Challenge my irrational demand for approval by doing one thing each day (for the next week) that I would normally avoid doing because of fear it may lead to disapproval.