

# The history of cognitive behavioural therapy



**ASSIGN  
BUSTER**

This essay's purpose is to consider the supporting and refuting evidence for the above claims. Firstly, an outline of cognitive behavioural principles and therapeutic techniques will be presented. Then, an analysis of the applicability of the terms 'mechanistic', 'totalitarian' and 'arbitrarily imposed' to Cognitive Behavioural Therapy (CBT) will be given. Finally, the effectiveness of CBT as a form of therapy will be briefly evaluated.

The basic premise of CBT can be summarised in the statement, 'what you think decides how you feel' (Wilding & Milne, 2008). It is a therapy that addresses dysfunctional emotions, maladaptive behaviours and cognitive processes through goal-oriented, explicit, systematic procedures.

The approach is based on a combination of behavioural and cognitive principles. The core idea of the cognitive approach is that people's emotional reactions and behaviour are strongly influenced by their thoughts, beliefs and the meaning they give to situations they experience. Integrated into this therapy is the behaviourist perspective, which is by changing what we do, thoughts and emotions can also be changed.

Even though there are various forms of CBT, there are still a number of beliefs that generally underlie this approach. One of these is the view that clients' problems are at different points on a continuum, not in a different dimension altogether. In other words, there is an avoidance of seeing psychological problems as an oddity not affecting 'normal' people and labelling clients pathologically.

Additionally, CBT practitioners focus on the treatment of the symptoms in the here and now rather than analysing the clients' past to search for any

hidden meaning behind the situation. Their main concerns are the processes currently maintaining the problem, rather than the events that might have led to its development.

Another important principle is that problems should be seen as interactions between different systems in the person, which are categorised as cognition, affect (emotion), behaviour and physiology. These systems interact with each other in complex feedback processes and also interact with the social, familial, cultural and economic environment of the individual (Wilding & Milne, 2008). This kind of analysis helps the therapist to consider times when one or more systems are not correlated with others.

CBT also claims to adhere to the values of strong collaboration between therapist and client, advocates shorter therapy length and gives clients skills to manage their situation themselves. It also promotes scientific evidence of the efficacy of techniques as worthwhile rather than just clinical anecdotes.

Turning to some of the common techniques used in CBT, these can be divided into classical and operant conditioning and methods to alter cognitive functioning.

Firstly, classical conditioning is a form of learning in which the conditioned stimulus signals a second stimulus, such as when the experience of flying in a plane is directly associated with fear. Systematic desensitization is a technique to eliminate this anxiety through the client imagining the first stimulus to varying degrees, eventually being encouraged to face the situation in real life. Besides phobias, this method has been used effectively

with conditions such as impotence, social anxiety and obsessive compulsive disorder (O'Sullivan, 1991).

On the other hand, exposure techniques, such as flooding, expose the client to the phobic stimulus in real life and all at once. From a cognitive point of view, inescapable exposure leads patients to realise that the situation is not actually catastrophic and that they have the resources to confront it.

Physiologically, the release of endorphins in response to intense anxiety may partially account for its efficacy (Merluzzi, 1991).

Operant conditioning is controlled by its rewarding or punishing consequences. In this case, participatory modelling can be utilized, which is when the therapist models the desired behaviour and gradually induces the client to participate in it. Bandura (1977) demonstrated that this method was helpful for clients with a fear of snakes, but highlighted the point that it may not necessarily work with others, such as those who have social phobia.

This is because desensitizing someone to be in a social setting does not actually give them the skills to interact in this environment. Therefore, skills training is necessary for the person to initially learn a set of procedures consciously. Hopefully, they will then be able to remember these skills so they become unconscious actions.

Cognitive methods are also an integral part of CBT. Ellis's (1962) Rational-Emotive Therapy (RET) proposed the ABCDE model to examine cognitive processing. A refers to the activating condition or event, B is the belief about this and C is the emotional consequences of having this belief, while D is disputing the irrational beliefs and E is creating a new effective outlook. In

RET, the counsellor brings such beliefs to the client's attention, encourages them to challenge their validity and teaches alternative ways of thinking.

Similar to Ellis, Beck (1976) targeted automatic thoughts clients had in therapy by taking notice of these spontaneous utterances and analysing the underlying assumptions they make. He emphasized the collaborative therapeutic relationship, likening it to two scientists testing hypotheses (1989).

Despite the above beliefs exalting what CBT can achieve in therapy, there have been a number of criticisms targeted at this model. One of them is that CBT is too mechanistic in its approach, treating clients like machines without a conscious will of their own.

Ryle (2012) believes a scientific basis for understanding human nature is valid but insists that objectivity, in the sense of studying humans as objects, is inappropriate. He agrees that we need to observe and record evidence so others can replicate it but full evidence concerning human behaviour and experience can only be obtained by human beings and must include intersubjective understanding.

Furthermore, Teasdale, et al. (2002) criticises CBT for only being interested in specific meanings and beliefs on a conscious level. Targeting only this area may be insufficient to shift emotion, so it is suggested more holistic meaning should be addressed through non-evidential interventions such as guided imagery and mindful experiencing.

Craske (2010) concurs with this position, believing cognitive processing occurs without conscious awareness and is not amenable to logical reasoning. This raises a concern about overly cognitive focussed appraisal methods in therapy. As a response to these criticisms, there are movements to improve CBT by incorporating interventions such as mindfulness, acceptance and commitment therapy and dialectical behaviour therapy.

These therapies stress that the function of cognition is more important than the content of it. In other words, rather than trying to control and change the mind's content, the client focuses on lessening the impact of the thought on emotion and behaviour by decentring or accepting it, without attempting to change it (Craske, 2010). Teasdale, et al (2002) states that incorporating such techniques lessens the relapse rate for depression in clients.

On the other hand, there is some validity to the argument that CBT, in its more unaltered form, is not mechanistic but is as humanistic in nature as other contemporary therapies.

Watson and Geller (2005) studied clients' ratings of client-therapist working alliance conditions in CBT and process-experiential therapy. It was found that therapists who had empathy, congruence and acceptance, regardless of which therapy type employed, were perceived as the most effective. The research discovered that there was no difference in the level of the therapist's self disclosure between therapies. In practice, the charge of a mechanistic and unfeeling demeanour, in regards to the therapeutic relationship at least, does not seem to hold true.

Regarding CBT's techniques, it is significant to remember that cognitive methods are not an end in themselves, but are in the service of emotional and behavioural change. The ultimate goal of therapy is not simply intellectual insight but reduced emotional stress, greater self-efficacy and improved coping skills. Additionally, psycho-education is not a standalone treatment but needs to be integrated into intervention plans. CBT focuses on encouraging the client to do something, which leads to experiential insight and cognitive change rather than just talking about the problem.

House (2008) also highlights the transformative nature of well integrated psycho-education, arguing that sometimes simple technical information is sufficient for some patients' concerns. For instance, basic education about the instinctual reaction of fight or flight for someone with panic attacks may help ease their anxiety immeasurably.

Although, it is vital to be careful not to pathologize a patient to the point where they feel helpless, it can also be beneficial to 'name the beast', by identifying the problem the client is faced with. This can bring the client awareness of the universality of their predicament and give them hope for recovery when they realise others have overcome this same malady (Yalom, 1995).

In the end, however, even if it can be argued that CBT is somewhat mechanistic, Hall & Iqbal (2010) highlight the fact that the client still has free will in the therapeutic process. They can opt out of activities such as homework if they want to and only choose to accept the parts of the CBT doctrine they agree with. Of course, there can be some consequences for the

outcome of therapy if they do so. So, in reality, there is a fine line between choice and indoctrination.

Another accusation made against CBT is that it is totalitarian in nature, being controlled by one authority that allows no opposition.

This criticism is not surprising considering its preferred intervention status by many governmental mental health services in Western countries. Supporters of CBT have had to match the language of powerful institutions to attain its current position and be taken seriously. Once CBT has passed through its phase of being idealized as a cure all remedy by some practitioners and bureaucrats, it may likely be seen as just one of many viable methods available.

Grant (2004) points out CBT is not one single entity but a broad church of therapies ranging from explicitly technique focussed styles to standardized computer CBT packages or highly structured manuals used by health care professionals at low cost at the other end of the spectrum. The latter seems to be where critics target their attacks, but this cannot take away from the value and richness of individual experience in more tailor made approaches of this therapy.

Furthermore, there is not one single organisation that can truly claim to represent this therapy as a whole. Dobson & Dobson (2009) thinks it is no more appropriate to state that there is only one cognitive-behavioural approach than it is to say that there is one monolithic psychoanalytic therapy.



The World Congress of Behavioural and Cognitive Therapies, for example, incorporates experts from a variety of therapeutic disciplines under this general umbrella at its conventions. Likewise, the International Association for Cognitive Psychotherapy is an organisation which brings together members of cognitive and cognitive-behavioural therapy associations but does not seek to impose a single style of intervention that members must adhere to.

A third accusation targeted at this therapy is that it arbitrarily imposes ways of thinking, feeling and behaving on the client. This criticism implies that CBT forces people to interact in certain ways without any underlying principles supporting this stance.

In CBT theory, the emphasis is placed on the description and challenging of the links between thinking, feeling and acting. Ryle (2012) points out that when CBT is based on a skilful analysis of the individual and sensitively carries out its plan, this can clearly be an effective ingredient in therapy. However, when it is expressed through simple-minded analyses and condescending assertions of the patient's faulty thinking, it can be experienced as critical or disrespectful to the individual needs of the person.

Ryle (2012) goes on to state that therapists' positive responses to more effective behaviours may be beneficially reinforcing but in the case of persistent negative ones, especially when these undermine therapy, some practitioners have little theoretical understanding of what to do. In such cases, CBT therapists rely upon patient compliance with its technical

procedures and the personal qualities of the practitioner to maintain the therapeutic work.

Nevertheless, it can be argued that there are consistent rules that guide practice, rather than imposing rules randomly. Dobson & Dobson (2009) believe that practitioners need to follow underlying theories for the therapy to be efficacious. When practitioners of other models use CBT strategies, they are not actually using this therapy to its full strength. For it to be the most beneficial, they must adopt the principles of CBT with their corresponding techniques.

According to the 'Encyclopaedia of Behaviour Modification and Cognitive Behaviour Therapy', there are some basic tenets that all kinds of CBT are in general agreement with. These include the importance of taking into account and challenging negatively biased thoughts, assumptions, and beliefs. Also, CBT attempts to change behavioural excesses (e. g. binge eating) and behavioural deficits (e. g. avoiding phobias), and supplement skills deficits through modelling and psycho education.

Kazantzis, Reinecke & Freeman (2010) concur with the perspective that certain underlying principles must be followed. Different therapies can address the same problem effectively, but the success of any one given approach depends on practitioners' understanding and adherence to the model they are practicing. Therefore, practically speaking, it is not the surface description of what patients are doing which is important; it is why they are engaging in the task that is fundamental to the process and outcome.

A flexible adherence model can be seen as a moderated version to the above perspective. It is obvious to anyone who has performed counselling that there is no one best way to conduct the therapeutic intervention each time. However, flexible adherence is still different from a total eclectic approach, when a therapist uses anything that works in the moment (Kazantzis, Reinecke & Freeman, 2010).

Regarding the effectiveness of CBT, it can be argued that one reason it is claimed to be more successful than other models by adherents is to justify its status as a preferred therapy by many organisations in the early 21st century. The extent to which this proclamation holds true in reality is a point of debate.

A review of 16 meta studies across a wide range of disorders (Butler, et al., 2006) revealed some interesting results. CBT was shown to be highly effective for adult unipolar depression, anxiety disorder, with or without agoraphobia, social phobia, panic disorder, generalized anxiety disorder, post-traumatic stress disorder, childhood anxiety, depressive disorders, compared to no-treatment, a wait list or placebo controls.

Furthermore, it was highly effective for bulimia nervosa and showed superior outcomes compared to pharmacotherapy. Regarding treatment of schizophrenia, it proved more beneficial for the patient when used in conjunction with pharmacotherapy.

Butler, et al. (2006) found that the rate of relapse was low for depression and panic disorders and half the rate of when just pharmacotherapy was used in

intervention. This rate was maintained over a follow up period of 6 to 24 months.

However, its detractors maintain that there is a shortage of research to show the effectiveness in real world situations as opposed to research investigations.

As Ryle (2012) shows, demonstrating clinically useful effects for a psychotherapy model are formidable. Obviously, therapy is not comparable to the prescribing of a drug; it involves two people and what happens between them is only partly determined by the model of therapy. Trying to overcome this by delivering highly systemized therapy seems to be incompatible with a humanly respectful therapy and cannot eliminate the individual variations in therapists' work in any case. Indeed, the effects of factors common to any therapy delivered with reasonable tact and attention are difficult to distinguish from the results of specific interventions.

David Richards (2007), a past president of the British Association for Behavioural and Cognitive Psychotherapies (BABCP), attributes the growing criticisms of CBT to its selective use of evidence and to the naive belief that the randomized control trial (RCT) is the only weapon the profession now needs. He observes how CBT therapists themselves write the research questions that now get funded. As a result, reviews have shown that RCTs can both exaggerate and underestimate the likely real effect of certain interventions.

Further to this, he says that most CBT trials are small and poorly executed and the quality thresholds for RCTs in NICE's (National Institute for Health

and Clinical Excellence) guidelines are notoriously low, which allows the meta-analyses of small poor quality studies to direct policy.

Ryle (2012) also laments the fact that some research into CBT makes unproven claims about what can be achieved in a clinical setting. He points to the unsubstantiated contention that it is possible to take the results of experiments conducted by charismatic CBT proponents in highly controlled environments and implement them in the widespread manner suggested.

As there have been studies showing the positive effects of CBT, there are also many studies that show the opposite. CBT for anxiety and depression was found to be less effective on older adults compared to middle age people or adolescents (Kraus, Kunik & Stanley, 2007). The rates of relapse for depression in a meta-analysis reported it was 29% after a year and 54% within 2 years (Vittengl, et al., 2007).

In a review of naturalistic studies, short term CBT for a variety of disorders had limited long term benefits 2 to 14 years after treatment was delivered (Durham, et al., 2005). Hall & Iqbal (2010) revealed that there was no significant difference between CBT, interpersonal therapy and drug therapy in case of mild depression. Concerning severe depression, superior recovery rates for both interpersonal therapy and medication accompanied with clinical management was noted, compared to those for CBT.

Just as a number of questions can be asked about the reliability of research in psychotherapy generally, these same queries can be put to those who conduct CBT research. Firstly, do patients continue to maintain improvement after the observation period or are positive results a one off? Are research

outcomes better than what would be achieved by a placebo? Also, has a valid and large enough sample been selected fairly so real comparisons can be made between one therapy and another?

If these questions cannot be sufficiently addressed, it is justifiable to doubt some of the grandiose claims about its effectiveness that supporters of the CBT movement claim as fact. Hall argues that CBT has won the public relations campaign compared to competing therapies. Consequently, it has more 'face validity' in the media and wider community so is the most funded model (Hall & Iqbal, 2010).

In conclusion, whether therapists champion or disdain it, CBT is a therapy that is undeniably a dominant force in therapeutic practice at this point in history. Claims have been made that it is mechanistic. This is a danger for CBT practitioners and health care workers who are inexperienced in its practice. Counsellors using CBT must ensure that they treat clients in a humanistic way, developing a healthy therapeutic alliance to be as effective as they can.

Additionally, critics have said CBT is totalitarian. As CBT develops, it has incorporated techniques from other areas of psychotherapy, such as mindfulness. It must be remembered that there are many varieties in this therapy, not simply the government sanctioned version of it. Also, CBT therapists generally need to ensure they have a sound theoretical grasp of the interventions they implement so they can change course or justify their decisions when necessary. In this way, they will not be accused of arbitrarily imposing its methods on clients.

Regarding its effectiveness, there is sizeable research that supports the positions of both supporters and detractors. There is a concern, however, that organisations that use CBT as their preferred therapy neglect the imprecise nature of research in social sciences. Sound qualitative studies involving other modes of therapy should also be taken into account when policy decisions are made.

**3270 words**