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Reading About . . .

Cognitive Therapy

Growing interest in the clinical and research aspects of cognitive–behavioural therapy (CBT) has led to an exponential increase in publications. To provide an overview of the area is therefore a daunting task. Psychiatrists wanting to read about CBT will have diverse needs: to develop clinical knowledge or skills; to critically evaluate the research literature; or to sound competent when discussing the applicability of CBT in the MRCPsych examination.

This paper will direct people to the literature that addresses those requirements and begins with an overview of standard clinical textbooks in the CBT field. To give insights into the wealth of research data on cognitive theory and therapy of emotional disorders, publications pertaining to depression will be briefly reviewed. Finally, comments are offered on recent publications which reflect the likely direction of future clinical developments.

General texts

As an unashamed convert to 'Beckian' CBT, the most well-thumbed text I possess is *Cognitive Therapy of Depression* (Beck *et al*, 1979). This is an excellent manual that guides the reader through 'how to do it' by providing a wealth of clinical examples and a clear exposition of the techniques employed. Even those who do not wish to target their CBT skills at depression will gain enormous insight into the approach from this text. It outlines the principal characteristics of CBT as a shortterm, problem-orientated approach which, through guided discovery, helps the patient to identify and challenge dysfunctional thoughts and maladaptive assumptions. It emphasises the collaborative nature of the therapy, and that therapists must share their knowledge of the cognitive model and CBT techniques with their patients, who may then understand the origins of their disorder and ultimately develop the skills to apply effective interventions independently.

Mark Williams' book, *The Psychological Treatment of Depression* (1992) is a well-written, comprehensive guide to both the theory and practice of CBT. It is also a valuable teaching aid as it incorporates exercises which encourage trainees to practise specific cognitive and behavioural techniques. The second edition provides an up-to-date account, and revisions of the clinical section reflect recent developments, such as the application of CBT to chronic depressive disorders. While the above texts use depression as the vehicle to explore the therapeutic approach, a detailed manual on anxiety disorders has also been produced by Beck and colleagues (1985).

Two more general texts are invaluable to the novice therapist. Beck's (1976) original contribution *Cognitive Therapy and the Emotional Disorders* is a short volume that enables professionals from all disciplines to gain a broad understanding of the cognitive model. *Cognitive Behaviour Therapy for Psychiatric Problems* (Hawton *et al*, 1989) is destined to be the standard modern clinical reference manual. Leaders in the CBT field have been drawn together (e.g. Clark on anxiety disorders, Salkovskis on obsessional disorders) and have produced an accessible and thorough account of CBT applications of uniform high quality. An alternative, the *Comprehensive Handbook of Cognitive Therapy* (Freeman *et al*, 1989), follows a slightly different format, covering theory and therapy separately. It is a more extensive volume, drawing on a larger number of contributors, and perhaps suffers for this. It is not as tightly edited as Hawton's book, which has led to some overlap between chapters. However, the wide range of topics covered make it a valuable library reference.

Persons *Cognitive Therapy in Practice* (1989) is a basic clinical introduction aimed at novice therapists. It emphasises that CBT, as opposed to the random use of cognitive and behavioural techniques, begins with a cognitive–behavioural formulation which implicitly guides the therapist in the selection of which specific intervention to employ in a given situation. Scott *et al* (1989) have edited a clinical manual targeted at more experienced therapists trying to apply CBT in less well researched areas such as with sex offenders and drug abusers.

The above writings are dominated by empiricism and represent the 'rationalistic' school of CBT. To explore 'constructivistic' models (where linear causality is replaced by circular, feedforward reflexive arcs), the writings of Guidano & Liotti (1983),

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Mahoney (see Dobson, 1988) and Dowd & Pace (see Freeman *et al*, 1989) provide useful overviews. Of particular interest to a British audience is the work of Anthony Ryle (1990) who has promulgated the model of 'cognitive analytic therapy' (CAT), which owes much of its theoretical understanding to object relations and Kelly's construct theories, and much of its practice to CBT.

In this model, neurosis is understood as the repetitive use of ineffective 'procedures' (repetitive mental or behavioural events). Therapy both identifies and attempts to modify these procedures, particularly those which shape relationships with others. The model should be amenable to research, and is attractive to many exponents because of its attempt to marry psychoanalytic and cognitive models.

Many people looking for accessible introductions to the field of CBT find the self-help literature a valuable first step. It is appropriate for clinicians to be familiar with these books as they can be used as an adjunct to therapy. Two texts popular with depressed patients I treat are *A New Beginning* (Emery, 1981) and *Feeling Good: The New Mood Therapy* (Burns, 1980). The latter is aimed at an 'American' audience and some patients may find the style off-putting. Ivy Blackburn's *Coping with Depression* (1987) is well organised, informative and the best British alternative available. For couples, Beck's (1988) book *Love is Never Enough* has proved useful.

Cognitive theories of depression

The cognitive model of emotional disorders states that "an individual's emotional response to an event or experience is largely determined by the conscious meaning placed upon it" (Beck, 1976). In depression, Beck suggests that three elements of psychological functioning are important: the negative cognitive triad (the biased views of the self, world and future); depressogenic schemata (the hypothesised diatheses for depression which remain latent until activated by stress); and habitual errors of reasoning (systematic thinking errors that maintain the dysfunctional beliefs). Recent reviews (e.g. Haaga & Beck, 1992) specify the types of stressors that may activate dysfunctional beliefs in different personality modes. 'Sociotropic' individuals may be stressed by negative interactions or rejection by others, whereas 'autonomous' individuals may be stressed by failure to achieve personal goals. As a maintenance model of depression, these explanations have received support from research findings. However, a recent review of the empirical status of the cognitive theory of depression by Haaga and colleagues (1991) highlights that there are still deficiencies in the causal model. The fact that the therapy is effective does not prove that the theory is valid.

A comprehensive review by Teasdale (1988) is perhaps the best recent exposition of a cognitive theory of depression. This 'differential activation hypothesis' indicates that it is the increased accessibility of negative thoughts after an initial shift in mood that may explain why some individuals suffer persistent rather than transient depression. The model offers a rationale as to why a biological or psychological event may precipitate major depression, and an explanation of the increased vulnerability to depression in individuals with high levels of premorbid neuroticism. It is suggested that this group show chronically enhanced accessibility to negative memories (particularly related to self) as a trait characteristic which acts in the same direction but independently of the state memory bias demonstrated in depression. Teasdale's paper and the review by Martin (1985) are particularly useful as a cognitive construction of neuroticism may lead to more effective treatment interventions with high *N*-score individuals with major depression.

For a more detailed knowledge of different cognitive models, Alloy *et al* (1988) provide an update of the learned helplessness paradigm, and the theoretical chapters of Dobson's (1988) handbook and Ingram's (1990) *Contemporary Psychological Approaches to Depression* provide accessible introductions. A concise and understandable theoretical text on the diverse literature relating to the applied cognitive psychology of emotional disorders was produced by Williams and colleagues (1988).

Outcome studies of CBT in depression

The review of the early studies (Williams, 1984), the meta-analyses published by Dobson (1989) and Svartberg & Stiles (1991), the evaluation studies reviewed by Andrews (1991) and the chapter on long-term outcome by Clark (1989), provide comprehensive overviews of outcome research. Overall, findings indicate that CBT is the most effective form of individual psychotherapy in depression and may be as effective as drugs in the acute treatment of unipolar out-patient depressive patients. The data on long-term outcome is less easy to summarise, as not all the drug-treated groups received adequate prophylaxis. In general, the relapse rate in those treated with CBT, either alone or in combination with antidepressants, is no greater (and in most studies was lower) than in those treated with pharmacotherapy alone. However, these reviews preceded the National Institute of Mental Health (NIMH) study.

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The results of the NIMH treatment study (Elkin *et al*, 1989) suggested that interpersonal psychotherapy was also an effective short-term psychotherapy for depression. In severe disorders, antidepressant drugs were the most effective treatment, and the improvement with CBT was hardly distinguishable from placebo. It is hard to reconcile these findings with all the previous data (27 outcome studies) supporting the efficacy of CBT in major depression. The most recent acute treatment study (Hollon *et al*, 1992) failed to find any differences in response to drugs or CBT even among severe cases. However, it may be that when data relating to therapist competencies, to long-term outcome, and predictors of response to different treatment formats are available, the explanations for these different results will be clearer. Interestingly, the NIMH follow-up study (Shea *et al*, 1989) suggested that relapse rates in those receiving CBT were lower than in any other group and the study of Evans *et al* (1992) found CBT to be as effective as maintenance antidepressant therapy in preventing relapse. This may well be what distinguishes CBT from other 'manualised' psychological therapies for depression, and long-term outcome studies of CBT versus other treatments rather than acute treatment studies will probably be the next research target.

The above publications broadly support CBT as an effective treatment of depression but do not help the clinician decide who should be offered this intervention or who should be offered drug treatment. Patient preference will partly dictate such choices, but the availability of a trained therapist is also critical: CBT is only likely to be effective if the therapist is highly skilled and adheres to the treatment model (DeRubeis & Freeling, 1990). Simmons *et al* (1985) showed that patients who scored highly on the learned resourcefulness scale (suggesting an internal locus of control) do better with CBT than with pharmacotherapy, although more recent papers have not supported this view. Other papers exploring mechanisms of change in CBT (e.g. Jarrett & Nelson, 1987) and how such may work (e.g. Teasdale, 1985) make absorbing reading and highlight a critical area for future research.

Future directions

Developments in CBT continue apace. As psychological problems do not occur in a vacuum, it is logical that clinical interventions are being promoted with families and with couples. The publications *Cognitive–Behavioural Therapy with Families* (Epstein *et al*, 1988) and *Cognitive–Behavioural Marital Therapy* (Baucom & Epstein, 1990) are useful additions to the literature. A concise and highly recommended text is *Cognitive Therapy with Couples* (Dattilio & Padesky, 1990) which gives an excellent and readable clinical introduction. As yet, these approaches are untried in large-scale research trials and so the texts may not represent the definitive therapy model. However, this is not the case for 'adjuvant psychological therapy' with cancer patients where outcome data have already been published (Greer *et al*, 1992). Skills in effective non-drug treatments for patients with physical disorders or abnormal illness behaviour would be beneficial to all clinicians, making the respective contributions of Moorey & Greer (1989) and Salkovskis (see Hawton *et al*, 1989) especially relevant.

The question arises as to whether CBT can be extended to treat those who present with more complex problems or with psychotic symptoms. Recent results of studies of combined drug and CBT treatments for chronic or severe disorders are encouraging (Kingdon & Turkington, 1991; Thase *et al*, 1991; Scott, 1992; Williams, 1992; Tarrier *et al*, 1993), making publication of the clinical manual on *Cognitive Therapy with In-patients* (Wright *et al*, 1993) timely. In some disorders, such as chronic depression, a cognitive formulation informs a systematic programme of interventions tailored to the individual. However, with psychotic disorders, a cognitive theory of aetiology is not promoted. Rather the educational and coping strategies that represent a beneficial part of the CBT approach are applied as an adjunct to drug therapies. Perris (1989) has written on the use of CBT with schizophrenia but his approach tends towards constructivistic models and is less overtly 'cognitive' than the model practised by Tarrier *et al* (1993) or the more rationalistic approach advocated by Kingdon & Turkington (1991). The latter research identifies core cognitive strategies as part of a normalising regime for psychotic patients, and in an open-outcome study this approach appeared to promote treatment compliance and symptom reduction. Tarrier *et al*'s (1993) study used one of two CBT interventions–coping strategy enhancement (CSE), or problem-solving (PS)–in combination with drug therapy. Both CSE- and PS-treated schizophrenic patients showed significantly greater reduction in their psychotic symptoms than those in the waiting period, and there was a trend for the CSE group to do better than the PS group.

Finally, it is likely that if psychiatrists were asked to write a new therapy 'wish list', high on the agenda would be a structured, effective, therapeutic approach to patients with personality disorders. A first step towards this goal may be *Cognitive Therapy*

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of Personality Disorders (Beck *et al*, 1990). This book provides a theoretical framework from which to develop coherent clinical interventions. The critical difference in the approach is that it is more schema focused, devoting more therapeutic time to exploration of the childhood origins of the schema. The therapist is more active, makes more use of the therapist–client interaction as a source of therapy material, and the course of therapy is longer. A recent study of this type of intervention (group dialectical behaviour therapy) compared to 'treatment as usual' produced modest but significant improvements in borderline patients who had engaged in repetitive deliberate self-harm (Linehan *et al*, 1991). Further outcome research in this area is awaited with interest.

Summary

The scientific approach advocated in CBT has increased its credibility with more biologically orientated therapists (who have remained sceptical of other psychodynamic models), making the approach acceptable to a broad group of psychiatrists. There is a rich clinical literature describing the techniques and applications of CBT in a wide variety of settings. The acquisition of a selection of the above texts offers a useful starting point, and scanning of major British and American psychiatry and psychology journals is likely to turn up at least one important paper every few months. Those with a commitment to research would benefit from subscribing to the journal *Cognitive Therapy and Research*.

CBT does not aim to be a panacea for every disorder, and cognitive therapists are critical of its overzealous use by inadequately trained or poorly informed therapists. To practise effectively, the therapist needs a coherent cognitive model of the problem being treated and, as such, must explore the theoretical background literature and critically evaluate the data from process and outcome research. Hopefully, this 'scientist-practitioner' approach, tracing the emergence and development of the theory and principles of the model underpinning the therapy, means that cognitive therapists practise what they preach.

References

ALLOY, L., ABRAMSON, L., METALSKY, G., *et al* (1988) The hopelessness theory of depression: attributional aspects. *British Journal of Clinical Psychology*, **27**, 5–21.

ANDREWS, G. (1991) The evaluation of psychotherapy. *Current Opinion in Psychiatry*, **4**, 379–383.

BAUCOM, D. & EPSTEIN, N. (1990) *Cognitive–Behavioural Marital Therapy*. New York: Brunner/Mazel.

BECK, A. T. (1976) *Cognitive Therapy and the Emotional Disorders*. New York: Basic Books.

—— (1988) *Love is Never Enough*. London: Penguin.

—— & FREEMAN, A. (1990) *Cognitive Therapy of Personality Disorders*. New York: Guilford Press.

——, RUSH, A. J., SHAW, B. J., *et al* (1979) *Cognitive Therapy of Depression*. New York: Guilford Press.

——, EMERY, G. & GREENBERG, R. (1985) *Anxiety Disorders and Phobias: A Cognitive Perspective*. New York: Basic Books.

BLACKBURN, I. M. (1987) *Coping with Depression*. Edinburgh: W. & R. Chambers.

BURNS, D. (1980) *Feeling Good: The New Mood Therapy*. New York: Signet.

CLARK, D. (1989) Cognitive therapy for depression and anxiety: is it better than drug treatment in the long term? In *Dilemmas and Difficulties in the Management of Psychiatric Patients* (eds K. Hawton & P. Cowen). Oxford: Oxford University Press.

DATTILIO, F. & PADESKY, C. (1990) *Cognitive Therapy with Couples*. Sarasota: Professional Resource Exchange Inc.

DERUBEIS, R. & FREELING, M. (1990) Determinants of change in cognitive therapy of depression. *Cognitive Therapy and Research*, **14**, 469–482.

DOBSON, K. (1988) *Handbook of Cognitive–Behavioural Therapies*. London: Hutchinson Education.

—— (1989) A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, **57**, 414–419.

ELKIN, I., SHEA, M., WATKINS, J., *et al* (1992) National Institute of Mental Health treatment of depression collaborative treatment programme. *Archives of General Psychiatry*, **46**, 971–982.

EMERY, G. (1981) *A New Beginning*. New York: Simon & Schuster.

EPSTEIN, N., SCHLESINGER, S. & DRYDEN, W. (1988) *Cognitive–Behavioural Therapy with Families*. New York: Brunner/Mazel.

EVANS, M., HOLLON, S., DERUBEIS, R., *et al* (1992) Differential relapse following cognitive therapy and pharmacotherapy for depression. *Archives of General Psychiatry*, **49**, 802–808.

FREEMAN, A., SIMON, K., BEUTLER, L., *et al* (1989) *Comprehensive Handbook of Cognitive Therapy*. New York: Plenum Press.

GREER, S., MOOREY, S., BARCH, J., *et al* (1992) Adjuvant psychological therapy for patients with cancer: a prospective randomised trial. *British Medical Journal*, **304**, 675–680.

GUIDANO, V. & LIOTTI, G. (1983) *Cognitive Processes and Emotional Disorders? A Structural Approach to Psychotherapy*. New York: Guilford Press.

HAAGA, D., DYCK, M. & ERNST, D. (1991) Empirical status of cognitive theory of depression. *Psychological Bulletin*, **110**, 215–236.

—— & BECK, A. T. (1992) Cognitive therapy. In *Handbook of Affective Disorders* (2nd edn) (ed. E. S. Paykel), pp. 511–524. Cambridge: Cambridge University Press.

HAWTON, K., SALKOVSKIS, P., KIRK, J., *et al* (1989) *Cognitive Behaviour Therapy for Psychiatric Problems*. Oxford: Oxford University Press.

HOLLON, S., DERUBEIS, R., EVANS, M., *et al* (1992) Cognitive therapy and pharmacotherapy for depression: singly and in combination. *Archives of General Psychiatry*, **49**, 774–781.

INGRAM, R. (1990) *Contemporary Psychological Approaches to Depression: Theory, Research and Treatment*. New York: Plenum Press.

JARRETT, R. & NELSON, R. (1987) Mechanisms of change in cognitive therapy of depression. *Behaviour Therapy*, **18**, 227–241.

KINGDON, D. & TURKINGTON, D. (1991) The use of cognitive behaviour therapy with a normalizing rationale in schizophrenia. *Journal of Nervous and Mental Diseases*, **179**, 207–211.

LINEHAN, M., ARMSTRONG, H., SUAREZ, A., *et al* (1991) Cognitive–behavioural treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, **48**, 1060–1064.

MARTIN, M. (1985) Neuroticism as predisposition towards depression: a cognitive mechanism. *Personality and Individual Differences*, **6**, 353–365.

https://doi.org/10.1192/bjp.165.1.126 Published online by Cambridge University Press

MOOREY, S. & GREER, S. (1989) *Psychological Therapy for Patients with Cancer*. Oxford: Heinemann Medical Books.

PERRIS, C. (1989) *Cognitive Therapy with Schizophrenic Patients*. New York: Guilford Press.

PERSONS, J. (1989) *Cognitive Therapy in Practice: A Case Formulation Approach*. New York: W. & W. Norton.

RYLE, A. (1990) *Cognitive–Analytic Therapy: Active Participation in Change*. Chichester: John Wiley & Sons.

SCOTT, J. (1992) Can cognitive therapy succeed when other treatments fail? *Behavioural Psychotherapy*, **20**, 25–36.

——, WILLIAMS, J. M. G. & BECK, A. T. (1989) *Cognitive Therapy in Clinical Practice: An Illustrative Casebook*. London: Routledge.

SHEA, M. T., ELKIN, I., IMBER, S., *et al* (1992) Course of depressive symptoms over follow-up. *Archives of General Psychiatry*, **49**, 782–787.

SIMMONS, A., LUSTMAN, P., WETZEL, R., *et al* (1985) Predicting response to cognitive therapy of depression: the role of learned resourcefulness. *Cognitive Therapy and Research*, **9**, 79–89.

SVARTBERG, M. & STILES, T. (1991) Comparative effects of short-term psychodynamic psychotherapy: a meta-analysis. *Journal of Consulting and Clinical Psychology*, **59**, 704–714.

TARRIER, N., BECKETT, R., HARWOOD, S., *et al* (1993) A trial of two cognitive–behavioural methods of treating drug-resistant residual psychotic symptoms in schizophrenic patients. *British Journal of Psychiatry*, **162**, 524–532.

TEASDALE, J. (1985) Psychological treatments of depression: how do they work? *Behaviour Research and Therapy*, **23**, 157–165.

—— (1988) Cognitive vulnerability to persistent depression. *Cognition and Emotion*, **2**, 247–274.

THASE, M., BOWLER, K. & HARDEN, T. (1991) Cognitive behaviour therapy of endogenous depression. *Behaviour Therapy*, **22**, 469–477.

WILLIAMS, J. M. G. (1984) Cognitive–behaviour therapy for depression: problems and perspectives. *British Journal of Psychiatry*, **145**, 254–262.

—— (1992) *The Psychological Treatment of Depression*. London: Routledge.

——, WATTS, F., MACLEOD, C., *et al* (1988) *Cognitive Psychology and Emotional Disorders*. Chichester: John Wiley & Sons.

WRIGHT, J., THASE, M., BECK, A. T., *et al* (1993) *Cognitive Therapy With In-patients: Developing a Cognitive Milieu*. New York: Guilford Press.

Jan Scott, MD, MRCPsych, Department of Psychiatry, Division of Neurosciences, University of Newcastle upon Tyne, NE1 4LP

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