

ONE An Introduction to the Cognitive Behavioural Approach and Why it is Needed

*Alec Grant, Jem Mills, Ronan Mulhern
and Nigel Short*

Learning objectives

After reading this chapter and completing the activities at the end of it you should be able to:

- 1 outline the cognitive behavioural approach to helping people with mental health difficulties in terms of the following key concepts:
 - the role of meaning, emotion and behaviour in mental health difficulties
 - problem and goal identification
 - the therapeutic alliance and case formulation, in relation to cognitive behavioural intervention strategies.
- 2 identify the significance of cognitive behavioural interventions in relation to:
 - the need for evidence-based mental health care internationally
 - problems concerning the dissemination of the cognitive behavioural approach internationally
 - problems regarding the dissemination of the cognitive behavioural approach in the UK
 - how the UK picture compares with that of other countries.

The cognitive behavioural approach

The role of meaning, emotion and behaviour in mental health difficulties

All cognitive behavioural (CB) interventions rest on the assumption that any of us may develop mental health difficulties if the meanings we give to specific

2 Cognitive Behavioural Therapy in Mental Health Care

events are sufficiently upsetting. When we are aware that something very pleasant is about to happen to us we usually feel happy and excited. However, if we attach distressing meanings to events we are equally likely to experience distressing emotions. For example, following the death of a partner, someone may feel continual and extreme sadness because of a deeply held belief that they have lost their *only* source of happiness in life (Greenberger and Padesky, 1995). Another individual who hears personally abusive and critical voices, and thinks that they are true, is likely to experience both low mood and anxiety (Mills, 2000).

Distressing meanings and emotions are, in turn, likely to influence changes in behaviour. Someone who feels continual sadness and believes that life holds no further happiness will very likely avoid doing activities previously experienced as pleasurable. Another who both fears and believes the voices they hear may increasingly hide away from contact with relatives and friends. From a CB perspective, the linkage of thoughts and emotions with behaviour serves to keep individuals with mental health difficulties stuck in a 'vicious circle', within which *what they do* both follows from, and serves to confirm, *what they believe* (Hawton et al., 1989).

Some, but certainly not all, of those individuals may also interpret events as more threatening or personally harmful than they really are because of deeply ingrained beliefs and rules for living learned at a much earlier stage in life. In a relatively 'silent' or tacit way, these influence how individuals make sense of their day-to-day experiences, the world and other people (Persons, 1989; Greenberger and Padesky, 1995; Mills, 2000).

Identifying problems and goals

The CB approach provides an empowering, person-centred and structured framework for collaborative working between practitioners and clients. The approach aims to enable mental health service users to make better sense of their difficulties by means of a journey of personal discovery and consider more useful ways of dealing with those difficulties. To this end, during the process of assessment, it is important that people are assisted in making explicit both the problems they want help with and the goals they want to work towards (Hawton et al., 1989; Fox and Conroy, 2000).

The therapeutic alliance and case formulation

With the practitioner ever mindful of the quality of, and threats to, the therapeutic alliance between both parties in the relationship, a developing case formulation emerges from the assessment process (Persons, 1989; Mills, 2000). The formulation is a written, usually diagrammatic, representation of clients' difficulties (this is discussed in detail in Chapter 2). It clarifies the links between troubling events and circumstances and how the client thinks, feels and behaves towards those, and takes into account the quality of the therapeutic alliance between practitioner and client (Hubble et al., 1999a; Leahy, 2001).

Based on a trusting relationship, the case formulation should be thought of as an evolving, rather than static, device that provides a continual and developing intervention reference point for practitioner and client. Enabling clients to contextualise their difficulties and develop strategies for feeling more in control of them, it also helps in the process of achieving informed consent for each stage of the intervention. This is because frequent explanation and discussion are necessary in its development, often combined with guided reading relating to specific points. The case formulation thus provides a clear rationale and guide for practitioner and client in making problem-solving decisions at all stages in the process.

As is discussed in Chapter 2, it may be relevant in some circumstances to include in the formulation the ways in which core beliefs and rules for living, developed earlier in life, seem to be impacting on current difficulties. However, it must be stressed that developing the case formulation in this way should only occur following careful consideration and supervision discussions about the impact this may have on the client's sense of themselves and their ability to progress with a CB approach. In unskilled hands, a focus on core beliefs and associated rules for living can disempower individuals and make them feel worse than they did before seeking help (James, 2001). We are of the opinion, after Persons (1989), that a good case formulation should use the minimum necessary explanatory elements to account for someone's difficulties.

CB intervention strategies

In our view, *appropriate* intervention strategies only emerge from a case formulation that tries to explain how the individual's difficulties hang together in the simplest way possible and takes full account of their relationship with the practitioner. These strategies should aim to help individuals tackle their problems and move forward with their lives, so are always goal-related. Interventions take the form of collaboratively negotiated 'experiments' that enable the person seeking help to 'test out' the extent to which the thoughts underpinning their difficulties can be supported or whether it might be more productive to try out new ways of behaving in relation to perceived and actual difficulties. The overall aim is to help each individual work towards their goals and, with an eye to the future, develop more helpful, adaptive ways of being with themselves, and others, in their worlds.

Why CB interventions are needed

The need for evidence-based mental health care

We live in an era when, internationally, it is becoming increasingly difficult to justify the provision of non-research-based forms of mental health intervention. The CB approach to helping individuals with mental health problems is thoroughly evidence-based. In recent years, support for its provision can be seen in

4 *Cognitive Behavioural Therapy in Mental Health Care*

an ever-growing range of mental health problems where it has been found to be helpful (Barlow et al., 1999; Nathan et al., 1999). This range includes anxiety-based problems and depression (Hawton et al., 1989; Wells, 1997; Leahy and Holland, 2000; Department of Health, 2001a) and the severe and enduring psychoses (Gamble and Brennan, 2000; Jones et al., 2000; NHS Centre for Reviews and Dissemination, 2000).

However, in spite of the evidence for the effectiveness of CB interventions, many individuals suffering from mental health difficulties are unable to access the help that they require (Andrews and Henderson, 2000). Undoubtedly, this is in large part because of the increasing costs of healthcare internationally (Rachman, 1996). Aside from economic problems, however, prejudice continues to abound in mental health care with CB approaches often seen as prescriptive, mechanistic or, indeed, brutal (Clarke, 1999; Duncan-Grant, 1999). It is also likely that, both in clinical practice and education, many mental health professionals worldwide operate on the basis of 'custom and practice' or theoretical orientation rather than empirical research. In Chapter 16 we argue that mental health provider organisations tacitly collude with this trend in the service of maintaining a status quo that disadvantages service users (Grant and Mills, 2000). A final problem is that many mental health workers are understandably distrustful of the claims made in the name of evidence-based practice (Barlow et al., 1999; Bolsover, 2002; Brooker et al., 2002; Holmes, 2002) because of particular controversies associated with the concept. We share some of those concerns and Chapter 15 addresses selected key issues in evidence-based mental health care and CB practice.

CB provision – the UK scene

In concluding this chapter, it may be useful for readers to consider a brief example of some local problems concerning the dissemination of CB knowledge and skills. Practitioners in the UK desperately need training and education in this area because, reflecting the global picture, the public-sector provision of effective interventions for users of mental health services has been grossly inadequate to date. In this context, the National Service Framework for Mental Health stresses the urgency of expanding the provision of evidence-based training and education in mental health care generally to include CB interventions specifically (DoH, 1999a). Such provision would enable practitioners to respond appropriately to individuals with 'common' mental health problems encountered in primary care, including people with anxiety-related and mood disorders, and those people who suffer from psychotic problems.

In 1998, the Department of Health called for a greater investment in staff training to support this modernising agenda to ensure that effective interventions would be offered where they were most needed and would be likely to achieve the most impact (DoH, 1998). In line with this policy, a study conducted by Brooker et al. (2002) aimed to map university-accredited, post-qualifying training and education for mental health professionals in England, to

equip them to work with people with serious mental health problems. Sadly, among a raft of other findings, Brooker and his colleagues reported that, in university mental health teaching departments, the provision of training and education in evidence-based practices generally, and in CB approaches specifically, seemed to be the exception rather than the rule.

SUMMARY

- Meaning, emotion and behaviour play a significant role in mental health difficulties.
- During assessment of such difficulties, problems and goals are made explicit.
- The therapeutic alliance and case formulation are pivotal in the CB approach.
- CB intervention strategies proceed from a developing case formulation.
- There is a need for evidence-based mental health care internationally and the CB approach has a strong research base.
- There is a gap between mental health need and effective, CB interventions throughout the world.
- This can be accounted for by increasing costs of healthcare provision, negative perceptions of CB interventions and evidence-based practice and professional and organisational resistance to change.
- The modernising agenda of mental health care in the UK calls for evidence-based training, education and practice.
- Evidence-based mental health training and education is the exception rather than the rule in the UK.
- This picture may usefully be compared and contrasted with provision in other countries.

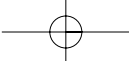
Activities

- Identify and make contact with CB practitioners locally.
- Explore attitudes towards the CB approach in your organisation.
- Explore the gap between the need for, and provision of, CB interventions in your area.

Further reading

Greenberger, D., Padesky C.A., 1995, *Mind Over Mood: A Cognitive Therapy Treatment Manual for Clients*. New York: Guilford Press.

An excellent self-help manual that would be of great help to mental health workers who wish to learn about the approach by working through their own difficulties in a structured and sequential way.



6 *Cognitive Behavioural Therapy in Mental Health Care*

Gamble, C., and Brennan, G. (eds) 2000, *Working with Serious Mental Illness: A Manual for Clinical Practice*. London: Ballière Tindall in association with the Royal College of Nursing, Harcourt.

This book is a lively and informative text for mental health workers who are trying to help individuals with psychotic difficulties.

Nathan, P.E., Gorman, J.M., and Salkind, N.J., 1999, *Treating Mental Disorders: A Guide to What Works*. New York: Oxford University Press.

This book provides a brief overview of the main features of all mental disorders, along with a summary of empirically supported treatments.

