Cognitive Therapy in Groups

Guidelines and Resources for Practice

Second Edition

Michael L. Free

School of Applied Psychology, Griffith University, Australia

John Wiley & Sons, Ltd

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To Paul Conrad

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About the Author

Michael Free is a lecturer in clinical psychology at Griffith University, Brisbane, Australia. He trained as a Clinical Psychologist at The University of Canterbury in Christchurch, New Zealand, qualifying in 1980. He then worked for the Queensland Health Department in a variety of positions in adult psychiatry for 12 years before obtaining his present position in 1993. He obtained his PhD in 1997 for research on the relationship between biological and psychological processes during recovery from depression. He has published a number of research papers on depression. Michael continues to be active in research and maintains a private practice in Ipswich, a regional centre outside Brisbane. He is currently researching his next book, with the working title 'Cognitive Therapy and the Teachings of Jesus', an integration of the authentic teachings of Jesus with cognitive therapy.

Preface to the Second Edition

The preliminary work for the Group Cognitive Therapy Program on which the first edition of this book is based was commenced in 1985, as part of my work at what was then the Woodridge Community Psychiatry Service. The program was fine-tuned over several cohorts of participants and was then used in collecting data for my PhD studies and general service delivery within the clinic. The resulting program was published in *Cognitive Therapy in Groups: Guidelines and resources for practice* in 1999. Since 1999 there have been a number of developments in cognitive therapy and I have continued to refine my own practice to the degree that a revision of the program was appropriate. In this period there have been three major developments in cognitive therapy: the increasing interest in the *process* of negative thinking as reflected in cognitive distortions and Logical Errors, the increasing interest in Schemas as reflected in the widespread practice of 'Schema Therapy' (e.g. Young, Klosko & Weishaar, 2003) and the development of sophisticated cognitive theories of the anxiety disorders (e.g. Wells, 1997).

In my own practice I continuously strive to incorporate these and other developments, to enhance the communication with the participant or client, to reduce unnecessary steps in the therapeutic process and to simplify those aspects of therapy that participants and clients consistently have difficulty with. I have also received a number of constructive comments from users of the earlier program and have tried to take notice of those and develop ways of addressing them.

In addition to these considerations, it has become clear that modern life necessitates as much flexibility as possible in the delivery of therapy. Some consumers of therapy are inpatients, some are residents in correctional facilities and some are very busy people with multiple commitments. To provide therapy for as many people as possible it is necessary either to develop multiple forms of the therapy, or develop a therapy that is sufficiently flexible to be delivered in multiple formats.

Two further, related aspects of early 21st Century life are important to consider: the growth of the Internet and the very wide availability and use of presentation software, especially Microsoft's 'PowerPoint'.

This second edition of *Cognitive Therapy in Groups* seeks to address all of those developments. It has been completely rewritten as a 25-session program in five modules. This allows it to be delivered in a variety of configurations ranging from daily or weekly one-hour sessions, weekly two-hour sessions, or half-day modules that combine a number of sessions. It has an increased emphasis on Schema work, including more emotional and experiential approaches to belief change. It also has a module on behaviour change, an element that was not present explicitly in the earlier program.

The major criticism made of the earlier program was that cognitive change, known in the program as 'countering', was not introduced till more than half way through the program. In this version, countering for 'surface' thoughts – Automatic Thoughts and Logical Errors, is introduced in Session Five.

The main difficulty experienced by participants in the previous program was with 'Logical Analysis', a complex method of challenging negative beliefs derived from McMullin (e.g. 2000). In this program challenging or analysing negative beliefs is presented within a much better articulated context and is broken into three kinds of analysis: Adversarial Analysis, Investigatory Analysis and Scientific Analysis. It is hoped that this allows the concepts to be presented in a less challenging manner.

The new version of the program seeks to take advantage of the Internet and electronic presentation software, in two ways. The previous edition had Overhead Transparency (OHT) templates included in the book as well as handout and worksheet templates to copy. For this version, separate PowerPoint presentations have been prepared for each session. These and other useful materials will be available on a website accessible to purchasers of the book. It is also hoped to publish updates of the various materials on the website from time to time. This version also includes a much greater number of worksheets than the first version.

The main features of the presentation of the original program have been retained. The aim has always been to provide a comprehensive group therapy program and as many essential resources as possible within the same package, so that an experienced therapist with a general theoretical knowledge of the theory of cognitive therapy and generic therapeutic and group facilitation skills, can run groups in most settings with minimal need for resources not available from the book. The only exceptions were and continue to be copyright assessment materials, which are of course readily available from commercial suppliers. The approach continues to be psychoeducational and the text is again written as full narrative script which can be read verbatim, but which the facilitator can adapt to his or her own vernacular. Each therapy session has the same structure: an introduction to the setting, instructions for reviewing Individual Work from the previous session, lectures, exercises and a summary, Individual Work to complete from that session and commentary on difficulties that might arise in that session. Two components have been added: an outline of the session for the therapist at the beginning of each session and a 'You will need for this session' section with a list of slides and other materials needed for that session to make it easier for the facilitator to prepare. Despite the wide penetration of the Internet and Microsoft software, there are settings that do not have access to either or both. Whilst the intention is to bring this version of the program to the forefront of technological development, it is realised that not all people or agencies using the book will have access to that technology. For this reason all the slides are reproduced in reduced format in alphabetical order in Appendix Six of this book, so they can be easily located, photocopied and made into transparencies. The worksheets and handouts are also available in Appendices Seven and Eight.

There have been a number of minor cosmetic changes. One such is referring to work done by participants between sessions as ‘Individual Work’, rather than ‘Homework’. The latter, I think, has negative connotations for many participants, since it may remind them of unpleasant school experiences. It also places them in an authority structure. ‘Individual Work’, on the other hand emphasises the individual responsibility and benefit of doing the work. It also acknowledges that sometimes the Individual Work can be done in the setting in which the session is conducted, for example when three or four sessions are offered over the course of a day.

Non-essential aspects of the earlier book have been omitted from this edition, to conserve space for essential components. There is no extended discussion of therapy, or of group therapy and there is no evaluation study. It is thought that the users of the book will not require convincing about those matters and in any event they are better addressed elsewhere.

Finally, there are a number of acknowledgements to be made. First, thanks to all the people who bought the first book. Second to Wiley who thought well enough of the first edition to commission a second. Third to my clients and colleagues who have made useful comments and suggestions. Fourth to Gill Clifford and Simone Rothë who read parts of the draft. Fifth to my colleagues in the Griffith University Clinical Psychology teaching team who helped make it possible to work on the manuscript and finally thanks to my wife Marian who has lived with me with this project for two and a half years, including during our long-service leave holiday together in Europe.

Part 1

Preliminary Considerations

Chapter 1

Introduction to the Program

Outline of Chapter One

1. The nature of the program
2. The search for effective, efficient and ethical psychotherapy
3. Provision of treatment in groups
4. The psychoeducational approach to psychotherapy
5. Manual-based therapy
6. Overview of the program

This is not just a program of group cognitive therapy. It is presented as a psychoeducational Group Cognitive Therapy Program, structured into 25 fully scripted sessions, together with other resources including OHT templates, handouts and worksheets, but it can be used in a variety of ways, including as a basis for individual therapy. All essential resources are included in the book and others are available on the website associated with the book. You can use the program exactly as it is in the book, presenting each session in sequence, using the words verbatim and doing all the exercises; you can use the PowerPoint presentations and worksheets, but make up your own words; or you can use bits of the program with individual clients, in individual therapy or in the context of other group programs. Although I run formal groups using the program, I myself find it most useful to have the PowerPoint presentations and worksheets available and to use them, roughly in sequence, with individual clients as appropriate in the course of their individual therapy. The program is designed to be flexible, so you can use the materials in any sensible way you wish. How you use it will depend on your own preferences and also the guidelines or constraints of the agency you work for. There are many benefits of doing cognitive therapy in groups for people with emotional and behavioural disorders, but the program presented here does not have to be done in a group for it to be effective.

The nature of the program

The Group Cognitive Therapy Program contained in this book consists of full scripts for a 25 session group therapy program aimed at identifying, challenging and changing negative cognitions and behaviour of participants who may be suffering from emotional disorders, including depression, anxiety disorders and excessive anger. Sessions are about an hour long and divided into 5 modules of 4–6 sessions each. Each module has a theme: Changing Surface Beliefs and Processes,

Exploring the Negative Belief System, Testing Beliefs, Changing Beliefs and Changing Counterproductive Behaviour. Sessions can be presented singly, two together, or in a block of four followed by a single session. Modules can be presented immediately after each other or with breaks between them. Sessions can be presented to groups or individuals and the program can be presented in community facilities such as school or church halls, outpatient or inpatient settings and in residential settings such as correctional facilities. It could conceivably be presented over the Internet. There will be some discussion in the next chapter as to how you choose a format.

Each script includes instructions for exercises that assist the participants in accomplishing the tasks of therapy. The book also contains various resources to aid in conducting the program, together with extensive notes on how to manage the process of therapy within the group.

The program conforms to a number of trends evident in the provision of psychotherapy over the past 30 years:

- provision of therapy in groups;
- use of manual-based therapy;
- use of a psychoeducational approach to psychotherapy;
- tailoring presentation of therapy to the needs and preferences of the client.

The search for effective, efficient and ethical psychotherapy

Psychological therapy for emotional disorders has been available for nearly a century. However that therapy has not been available for all people even in the countries in which it was developed. In Vienna at the turn of the century only the wealthy middle-class could afford to see Sigmund Freud and his colleagues. The same has been true for most of the twentieth century: many people who would have benefited from psychotherapy have not been able to get access to the service for a number of reasons. The main reasons have been as follows:

- Those people with lower incomes could not afford the fees charged by the therapists.
- There has been a shortage of adequately trained therapists in comparison to the number of people with appropriate conditions for treatment.
- There has been increased diversity of life-styles ranging from people who are extremely busy with little ability to make extensive, weekly time-commitments to others who have large amounts of unstructured time.
- There is increased pressure on service delivery agencies to make the very best use of their resources.

A major strategy to address these issues has been to make the delivery of psychotherapy more efficient and more effective, as well as to improve opportunities for people to obtain therapy, otherwise known as *equity of access* to therapy. In this

discussion *efficacy* is taken to mean the quality of the outcome of the therapy, especially in terms of the symptoms and conditions the patients present with for therapy. *Efficiency* is taken to mean the value of the outcome in comparison to the resources required. Improvements in efficacy and efficiency are expected to lead to increased access to therapy because the therapy can be delivered at a reduced cost and therefore to more people, given equivalent resources.

In addition to the ethical concerns, the economics of provision of health care services have become vitally important to governments and 'Third Party Providers', such as insurance companies. In the physical medicine area there has been a move towards accepted units of treatment for particular conditions and for health care providers to receive funding according to the mix of cases treated by their organisation. The same trend is evident in the mental health area, contributing to the imperative to improve the efficiency and effectiveness of psychological therapy.

A further development has been the increased awareness of options by consumers and with the rise of private practice clinical psychology there is an increased role of the preferences and desires of consumers. Private practitioners are aware that different clients will have very different preferences as to how they want their therapy delivered. Some want their therapy delivered within the context of a friendly chat, some want specific skills they can take away and some want a highly structured program.

There are therefore a number of reasons for offering therapy in groups: it is cost-effective in that it allows more people to be treated with the same resources and it is an alternative which is more appealing to some people than individual therapy. There are also benefits that come from doing therapy in a group: participants come to appreciate that they are not alone in their troubles and they have a ready-made accepting context within which to try out new behaviour.

Provision of treatment in groups

Perhaps the first person to provide therapy in groups was the psychiatrist Maxwell Jones who found during World War Two that he did not have enough therapy staff to treat the soldiers with 'war neurosis'. He found that he could treat these people quite effectively in groups.

The idea of treating people in groups has continued as the main paradigms of therapy have changed. Groups were developed for humanistic therapies, gestalt therapy and transactional analysis. When behaviour therapy was developed in the early sixties there were many successful attempts to do systematic desensitisation in groups (eg: Lazarus, 1961; Rachmann 1966a, 1966b; Paul & Shannon 1966). The same was true of cognitive therapy. Two landmarks in the development of Cognitive Therapy were the publication of the first major outcome study in 1977 (Rush, Beck, Kovacs & Hollon, 1977) and the publication of a treatment manual (Beck, Rush, Shaw & Emery, 1979).

Cognitive Behaviour Therapy has since become the dominant form of psychotherapy in most of the Western world and is the framework used for most of the empirically validated treatments. It was not long after the publication of *Cognitive Therapy of Depression* (i.e. Beck *et al*., 1979) that *Cognitive Therapy of Couples and Groups* (Freeman, 1983) was published. Unfortunately, although a number of group programs have been developed for specific populations (e.g. the group component of Linehan's Dialectical Behaviour Therapy (Linehan, 1993), there has not been much development of generic cognitive therapy group programs. This second edition of *Cognitive Therapy in Groups* seeks to continue the aim of the first edition in providing such a resource.

The psychoeducational approach to psychotherapy

There are a number of formats for group therapy, including group therapy in which interactions amongst all the members are regarded as important. Interactions can be organised by 'going around' the group to identify issues, by putting one person in the 'hot seat' who then becomes the focus of the group's communications, or can be unstructured.

The psychoeducational approach was one of the earliest formats used in group therapy. In what may have been the first clinical application of group therapy Joseph Pratt, a physician in Boston in the early years of the twentieth century, brought tuberculosis patients together in groups to teach them about their illness and to encourage them to support each other (Pinney, 1978). Two psychoanalysts, Louis Wender and Paul Schilder were responsible for initiating didactic group therapy during the 1930s. Wender, for example used lectures and illustrative examples together with leading questions followed by discussion of the answers (de Maré, 1972).

The psychoeducational format is consistent with the ethos of behaviourism. One of the themes evident in the 1960s with the advent of behaviourism was the demystification of therapy and the viewing of therapy as primarily an educational process. As behavioural techniques were applied to education, it was realised that this approach could also be used in therapy. The psychoeducational approach conformed closely with three of the philosophical values of behaviourism: it was procedurally specific, the active process did not require extensive inferences about unconscious processes and it empowered the patients by making them to some degree responsible for the process of therapy.

The psychoeducational approach involves the application of a number of behavioural techniques to the teaching of specific behaviours that are seen as part of therapy. The first step is to conduct a task analysis of the processes involved in the particular therapy. The processes are broken into teachable steps. The therapist then teaches the steps by the provision of clear information as to the behaviours required in the step. The information as to the behaviours required can be provided through written instructions, demonstration, or provision of a model of the finished

product. The patient then has the opportunity to perform the step by role-playing the behaviours with the therapist in the clinic, role-playing the behaviour in a simulated situation, or performing it in the natural environment. Finally, feedback is provided, which can include reinforcement as well as information.

A number of important behavioural principles are applied in psychoeducational programs:

- The information or prompting provided before or during the performance of the behaviour can be slowly faded or reduced.
- The behaviour can be shaped by positive reinforcement of successive approximations of the desired behaviours.
- Contingencies can be adjusted as the frequency of reinforcement is reduced.
- The contextual complexity of the performance situation can be gradually increased to approach similarity to the natural environment.

The psychoeducational approach has been applied to a number of problems, including assertiveness training, addiction problems, sexual deviation and dysfunction, anger management and social phobia. A number of well-known and well-evaluated psychoeducational group programs have been developed for depression, including those by Sank and Schafer, (1984) and Lewinsohn, Antonuccio, Steinmetz and Teri (1984).

Manual-based therapy

Another change in the delivery of therapy has been the move to manual based treatments. This has had its source in a number of factors, including the ethical stance of evaluating treatment, the need to train clinicians adequately and efficiently and more latterly the advocacy of empirically validated treatments.

Use of a manual to guide treatment is one of the criteria for an empirically validated treatment (King, 1997). This indicates the desirability of manual based therapy. Although, of course, having a manual does not in itself make a treatment better or empirically validated it does make it easier to evaluate a therapy when the procedures are clearly and specifically prescribed. It is then relatively easy to check that the example of the therapy being evaluated is indeed an example of the therapy it is purported to exemplify. It is also relatively easy to have the therapy conducted by multiple clinicians at multiple centres thereby reducing the possibility of bias from the effect of individual clinicians or specific schools of the particular therapy. It is hoped that publishing this manual will allow it to be used in evaluation studies.

The nature of the therapeutic relationship

Cognitive Therapy is not just a theoretical approach to psychopathology, nor a collection of techniques. It embodies a philosophy of therapy that may well be as responsible for its general acceptance and efficacy as the theoretical underpinnings

and the specific techniques. Fennell (1989) identifies the following characteristics of cognitive behaviour therapy (CBT). According to Fennell CBT is:

- Based on a coherent cognitive model of emotional disorder, not a rag-bag of techniques with no underlying rationale.
- Based on a sound therapeutic collaboration, with the patient specifically identified as an equal partner in a team approach to problem-solving.
- Brief and time-limited, encouraging patients to discover self-help skills.
- Structured and directive.
- Problem-oriented and focused on factors maintaining difficulties rather than on their origins.
- Reliant on a process of questioning and 'guided discovery' rather than on persuasion, lecturing, or debate.
- Based on inductive methods, so that patients learn to view thoughts and beliefs whose validity is open to test.
- Educational, presenting cognitive-behavioural techniques as skills to be acquired by practice and carried into the patient's environment through home-work assignments. (p. 173).

Most of these are still true in 2006. The main exceptions are that Cognitive (and CBT) therapists are more concerned now with the development of the problem emotions and behaviours in earlier life and are probably less directive in their approach to therapy. These characteristics embody the ethic and philosophy of cognitive therapy (and behaviour therapy and Cognitive Behaviour Therapy) and the relationship between therapist and patient derives from them. It can be seen that they emphasise a non-judgemental attitude to the acquisition and maintenance of symptoms or problem behaviours or emotions, a placement of responsibility on the patient for unlearning the old behaviours and emotions and acquiring the new ones and a placement of responsibility on the therapist to empower the consumer to make the changes they desire. If anything the developments since 1989 enhance the ethic of responsiveness, flexibility and empowerment on the part of the therapist. The non-judgemental attitude and emphasis on responsiveness to the patient's needs and desires can be seen to be equivalent to unconditional positive regard, as advocated by Carl Rogers and the explicitness of therapy can be extended to transparency in all aspects of the therapeutic process. There is also a demystification of both therapeutic content and process together with a clear emphasis on collaboration and respect between the therapist and the patient. The program presented in this manual is intended to embody this ethic and to promote and operate within the context of the kind of relationship described.

Overview of the program

The program will be discussed in detail in the following chapters, but before proceeding with the discussion of theoretical underpinnings in the next chapter it may

be useful to present an overview of the program. The program is in five modules: Changing Surface Beliefs and Processes, Exploring the Negative Belief System, Testing Beliefs, Changing Beliefs and Changing Counterproductive Behaviour. At several points in the program an increasingly sophisticated version is presented of the theory underlying the program. This encourages participants to come to an increasingly sophisticated understanding of acquisition and maintenance of their problem emotions and behaviour in the traditional psychological terms of predisposing, precipitating and perpetuating factors and also in terms of Negative Schema Content, misinterpretation of historical events and counterproductive behavioural strategies.

The first session is concerned with providing information about the program and setting the scene for psychoeducational group therapy. The main content of the program commences in Session Two with an educational orientation to the main principles of cognitive therapy. Participants are introduced to the concepts of Automatic Thoughts, Logical Errors and Schemas. They are then introduced to the ABC sequence of Activating event, Belief or thought and emotional Consequence. Participants are assisted to identify their surface beliefs over the course of the week between sessions and to write them in the three-column format, one column for each component of the ABC. The remaining sessions in Module One are concerned with identifying Logical Errors in surface thinking and changing them to alternative appropriate logic. Module Two is concerned with participants obtaining a comprehensive understanding of their negative thinking. Once participants have a substantial number of ABCs, they are taught to identify negative Schemas or core beliefs using the Vertical Arrow method (Burns, 1980). They then apply a number of approaches to achieving an overall understanding of the patterns and relationships amongst their negative beliefs, including putting the beliefs into categories, making a master list of all their beliefs and making ‘cognitive maps’. When the beliefs have been organised, the participants then apply a number of approaches to challenging their beliefs. Approaches presented in Module Three include an adversarial approach, an investigatory approach and an approach using the scientific method of operational definition, measurement and experimental design. In Module Four participants learn cognitive and experiential approaches to changing their negative thinking, which includes Negative Schema Content. Module Five works through a standard self-help approach to changing the counterproductive behaviour based on the negative thinking that has been challenged in the previous modules. It includes identifying the counterproductive behaviour, defining and counting it, simple context analysis, antecedent and reinforcement control strategies for behaviour change, behaviour rehearsal and problem solving. The program concludes with participants designing a maintenance plan, to reinforce and continue the gains they have made in therapy.

Each module is designed so that it is sequential but relatively autonomous. A participant can complete one module, then spend weeks, months, or longer, integrating the skills into his or her life and then do the next module, or they can be completed immediately one after the other.

Chapter 2
Theoretical Foundations

Outline of Chapter Two

1. Background to the theoretical basis for the program
2. A general model of disorders
3. Beck's cognitive model of depression (CT)
4. Ellis' Rational Emotive Therapy (RET)
5. McMullin's Cognitive Restructuring Therapy (CRT)
6. Young's Schema Therapy
7. The English cognitive therapists

Background to the theoretical basis for the program

The process of developing this therapy program is integrally related to my own development as a psychologist and the major theoretical influences of my work. As with many psychologists of my generation, my first introduction to cognitive therapy was the Rational Emotive Therapy of Albert Ellis. The next major milestone was the excitement generated by the publication of the initial outcome study of Aaron Beck's cognitive therapy (Rush, Beck, Kovacs & Hollon, 1977) and the subsequent publication of *Cognitive Therapy of Depression* (Beck, Rush, Shaw & Emery, 1979).

In 1985 as a clinical psychologist employed by the Queensland State Health Department, I was chosen to be in the team set up to establish a new psychiatry clinic in a fast-growing population area of 180,000 characterised by public housing, major social problems and paucity of services. A major mission of the clinic was to prevent hospitalisation of people with psychiatric disorders and to provide appropriate mental health treatment in the community. Perusal of the data available for the proposed catchment area of the clinic showed that approximately 25% of psychiatric ward admissions from the area were for depression. I therefore decided to develop an efficient and effective treatment program for depression.

About the same time a very experienced clinical psychologist within the Queensland Health Department, Paul Conrad, presented a series of workshops for psychologists employed by the Department. Conrad based his approach on Beck's theory as outlined in the 1979 text and also the work of Rian McMullin (McMullin & Giles, 1981). Beck's treatment was originally designed for depression and McMullin's was for agoraphobia.

Thus, this program was developed primarily as a treatment of depression and was based on Beck's theory as described in the 1979 text with some influence from

Rational Emotive Therapy and McMullin's approach to emotional disorders. Since the publication of the first edition of this book I have been working primarily in private practice and teaching clinical psychology. In my private practice work I have found it necessary to go beyond the work of Beck, Ellis and McMullin and to consider the role of childhood experiences and resulting Schema Content in the development of the emotional and behavioural problems that my clients were presenting with. I have found the Schema Focussed approach of Jeffrey Young very useful in that context and very compatible with my own approach. In addition I have found the theories of the English cognitive therapists such as Clark, Salkovskis, Fennell and Wells very compelling, both theoretically and practically, especially with respect to anxiety disorders. Their approach is probably most concisely presented in Wells, (1997) book *Cognitive Therapy of Anxiety Disorders*. The program described in this Second Edition incorporates the approaches of the English cognitive therapists and Jeffrey Young.

There are a number of reasons why it is important to articulate the particular cognitive model of emotional disorders that underlies the content and process of the Group Cognitive Therapy Program. In the first instance, no manual for treatment can cover all eventualities. There will be times when the therapist will need to devise a novel intervention to deal with a particular belief or behaviour demonstrated by a participant. Often a new intervention can only be devised from 'first principles', i.e. the theory on which the therapy is based. Second, as noted, there is no one external resource for the theory that underlies the program. Beck's model for depression is itself not a monolithic structure. There are a number of permutations that reflect the developments over the years and include different aspects of the model. It is important to articulate the precise model that underlies the therapy so those therapists using the program can understand the content and structure of the program and thereby conduct the program more effectively.

The model of the role of cognitive factors in emotional disorders that underlies the Group Cognitive Therapy Program will be presented below, particularly as applies to the process of intervention. As noted it is a synthesis of Beck's cognitive models of depression, anxiety and excessive anger with the approaches of Ellis (Ellis, 1962; Ellis & Harper, 1975; Ellis & Greiger, 1977), McMullin (McMullin & Giles, 1981; McMullin, 1986, 2000), Young (e.g. Young, Weisshaar & Klosko, 2003) and the English cognitive therapists. Each will be presented in outline, followed by the main aspects of the program influenced by that approach.

It should be noted that the content of this chapter is interpretation, not critique, of the various theories. This book is primarily intended to provide useful resources for therapists rather than to stimulate or affect academic debate on the many very salient theoretical issues that do exist in the area. All outlines of the theories presented in this chapter are extremely cursory and the reader is strongly advised to read the theories in the primary works cited.

A general model of disorders

A useful way of looking at any group of disorders and of understanding the clinical presentation of an individual patient suffering from a psychological or emotional disorder is in terms of predisposing factors, precipitating factors and maintaining factors.

Predisposing factors are events that occurred in the past or conditions that were present at the person's birth that did not directly cause the development of a disorder at the time, but which increased the probability of the eventual development of an emotional disorder. Predisposing conditions include genetic make-up, learning which occurs in childhood and even physical effects that are the results of nutritional characteristics. Predisposing factors are therefore usually present some substantial amount of time prior to development of the disorder.

Precipitating factors are the events that are associated with the manifestation of the disorder. In the absence of predisposing factors they may be the complete cause of the disorder, or they may simply contribute to the development of the disorder, perhaps in conjunction with predisposing factors. These are usually events external to the person, such as losing a job, finishing a relationship or experiencing a natural disaster. Such events can be sudden, such as a flood, or occur over a longer period, such as a drought. They can be internal, such as illness.

Perpetuating (or maintaining) factors are those factors that cause the disorder to continue to be manifest, once the precipitating event has occurred and possibly has ceased to continue to occur. Perpetuating factors may be external, such as the continuation of a drought or a bad relationship, or they may be internal such as continuation of an illness, a maladaptive behaviour pattern or way of interpreting social situations, or a lack of certain critical skills. Perpetuating factors may be continuations of the predisposing or precipitating factors, or may be new factors entirely. A perpetuating factor may be sufficient for the maintenance of the disorder by itself, or it may be contributory.

Interventions may address any number of the predisposing, precipitating, or perpetuating factors. A particular therapy usually has a 'primary premise' (Beckham, 1990) that it works because it changes one or more of these factors. The discussion below will identify the important aspects of the primary premise of the various theories and how these are incorporated in the program, or can be incorporated into the program by the group leader.

Beck's cognitive model of emotional disorders

Depression

There are four major components of Beck's theory of depression. They are all cognitive, in that they relate to internal events that the person may be aware of, but which are not directly observable by other people. These events are not physical, as are some other events experienced internally, such as pain or hunger pangs.

The four components are Automatic Thoughts, Schemas, Logical Errors and the Cognitive Triad.

Automatic Thoughts are a transient phenomenon. They include sentences and phrases that occur in the stream of consciousness and images of various kinds. They only exist as long as the thought is in consciousness. An adapted version of Beck's list of the characteristics of Automatic Thoughts is reproduced in Appendix Six and is included in the material for Session One.

Schemas, on the other hand, are permanent structures in the person's cognitive organisation which act as filters, templates or stereotypes to summarise the individual's experience of the world and enable him or her to organise their behaviour.

Logical Errors are errors in the process of reasoning, such that a distorted conclusion or inference is drawn from the facts. Examples are making a general conclusion on the basis of insufficient data, or deciding that an event has a totally negative meaning, on the basis of a lack of positive meaning. There are a number of lists of Logical Errors, otherwise known as 'cognitive distortions'. The list used in this program is my own, developed from Beck's.

The Cognitive Triad is concerned with the content of thoughts. In depression the content is mostly negative and is about the triad of self, world and future. Both Automatic Thoughts and Schemas have content and Logical Errors act to bias this content to make it more extreme. The result is extremely Negative Automatic Thoughts and Schemas concerning oneself, the world and the future that are derived from Logical Errors in interpreting sensory data.

Predisposing factors for a disorder may be genetic, or may be learnt in the person's developmental years. Beck is not specific as to the role of genetic factors in depression. He does see that depression may have originally been adaptive in certain circumstances and therefore is a genetic advantage in the evolutionary sense. Any inheritance pattern would therefore depend on the number of genes involved. Since the inheritance of a predisposition to depression is not simple, it is likely that a number of genes are involved and that therefore it is possible for individuals to have widely differing vulnerabilities for depression.

Beck is much clearer about developmental predisposing factors, stating that 'children exposed to a number of negative influences and judgements by significant figures would be prone to extract such negative attitudes and incorporate them into their cognitive organisation' (1987, p. 24). The position taken in this program is that such negative attitudes are the result of learning either by operant or vicarious learning processes, or by interpretative attributions about the causes of events. The negative interpretations are facilitated by the tendency of the individual to make *Logical Errors* in the interpretation of data. These Logical Errors, or *cognitive distortions*, largely reflect the individual's tendency (a) to overgeneralise in a negative way from the facts, (b) to relate the conclusion to themself in a negative way and (c) to develop absolute, rather than relative beliefs about the matter in question. The interpretations are then incorporated into *Schemas,* which are thought to be persistent structural cognitive entities, but which may be activated or deactivated.

The content of these Schemas can concern any class of experience a person may have, but of particular importance is the view of the self, the world and expectations about the future that the person develops. Beck calls these three aspects of the person's experience the *Cognitive Triad* and states that an important aspect of depression is the negative content of both Schemas and Automatic Thoughts in these three domains.

Thus a person, by virtue of the negative interpretation of developmental experiences, including experiences that may have been objectively negative, forms negative Schemas about themself, the world and the future. The Schemas may be conditional or absolute, as in 'if I fail at something important I am worthless'; or 'I am worthless'. Depression is then precipitated when an event occurs that is relevant to the Schema and therefore activates it. For the example this could be a failure experience in an activity seen as important.

Once a person becomes depressed, the classic symptoms of depression emerge together with a number of aspects of the person's biological state that are currently not described as being symptoms or signs of depression. Beck believes that these act together to maintain the depression.

It is important to note that Beck sees cognitive phenomena as only one aspect of depression. Other important aspects are the person's behaviour and physiological processes. Beck sees that cognitive aspects of depression are just one domain in which the clinician can intervene. He believes it is just as valid to intervene in the physiological or behavioural domains.

Core components

The following are what I believe to be the core components of Beck's theory:

- a tendency for cognitive processing to be negative;
- a tendency for Logical Errors to occur in cognitive processing;
- relatively persistent cognitive entities of negative beliefs and attitudes in the form of cognitive Schemas;
- transient cognitive phenomena which are derived from the persistent cognitive entities in the form of 'Automatic Thoughts';
- content of these phenomena relevant to depression is concerned with the value of future, the self and the world.

It follows that there are three main types of change which are supposed to occur during cognitive therapy:

- change from the automatic thinking of negative thoughts to the deliberate thinking of thoughts that are more consistent with objective reality;
- change in the process of thinking, that is reducing cognitive distortions or Logical Errors;
- modification of the more permanent cognitive structures, that is the Schemas.

Very frequently these changes will be to thought content that is concerned with the self, the world and the future.

Anxiety disorders

In talking about anxiety Beck distinguishes between fear and anxiety. He labels anticipation of damage *fear* and the unpleasant emotional reaction *anxiety*. Beck sees the causation and maintenance of anxiety as slightly different from that of depression. Beck believes that anxiety results from real or imaginary threats to ourselves, or to the safety, health or psychological state of any person within our personal domain, or to an institution or principle which we value. Thus with anxiety the loss or devaluation is in the *future*.

According to Beck, two major cognitive events are associated with anxiety. They are both judgements that are made about a situation: *primary appraisal* identifies the situation as a threat and assesses the probability, imminence and degree of potential harm. *Secondary appraisal* is an estimate of the individual's resources for dealing with the harm. The balance between the two appraisals determines the perceived risk (or danger) and hence, the degree of anxiety.

The same sort of Logical Errors associated with the value of the loss in depression apply during the appraisal process and result in the individual making inaccurate appraisals and therefore becoming needlessly anxious. In a process similar to depression, these Logical Errors lead the person to have inaccurate Schema Content about the danger associated with certain situations.

Anger

The meaning of an event is clearly important in both depression and anxiety. This is the central theme of the cognitive approach. The meaning of a sensory experience is separate from and different from the event itself and it can be highly personal. Because people make the Logical Errors already described, the meaning can be false. In depression the meaning is about *loss* and in anxiety it is about *danger*. In anger the meaning is about *transgression,* another person doing something that is *wrong* that has the potential to hurt the observer. According to Beck (1976) this can happen in three different kinds of situations: direct and intentional attack, direct and unintentional attack and violation of laws, standards, or social mores. Beck also sees it as necessary that the perceived threat *is* serious and that the observer evaluates the thing that is being attacked as important. But the threat should not be so great that the observer concludes that they may come to harm, in which case the emotion felt is anxiety. Or if they perceive that harm has already occurred and it is a loss then the emotion felt is depression. Beck (1976) also describes the conditions that accentuate anger after an offence has occurred as follows:

1. The offence is perceived as intentional.
2. The offence is perceived as malicious.

3. The offence is perceived as unjustified, unfair and unreasonable.
4. The offender is seen as an undesirable person.
5. There is the possibility of blaming or disqualifying the offender (p. 73).

Of these, the third is especially important, since often the cognition at the time of the anger is concerned with totally devaluing the offender.

Implications for the program

Conventional Cognitive Therapy for depression tends to move from working with Automatic Thoughts and cognitive distortions to working with Schemas. Schema Content is usually globally negative content about the self, one's social environment or the world. Therapy for anxiety disorders and anger generally involves more attention to Logical Errors. Schema Content addressed in the case of anxiety is about the dangerousness of the world and other people and in the case of anger is about the globally negative thoughts about another person or persons. The present version of this program starts with changing Logical Errors to appropriate logic, moves to replacing Negative Automatic Thoughts with appropriate, positive counter-thoughts and then moves to modifying Negative Schema Content. The present program is therefore quite appropriate for depression, anxiety and anger problems as conceptualised by Beck.

Ellis' Rational Emotive Therapy

Rational Emotive Therapy (RET) was developed by Albert Ellis over the same time period as Beck's Cognitive Therapy. RET is largely a theory of the origin of emotions, in particular the maladaptive emotions. It is not a theory specifically of depression, nor other specific emotions.

There are some strong similarities between the theories. Many of their central postulates are parallel and the overall concept is very similar. The theories can be seen as complementary in many ways. In fact, in the *Handbook of Rational-Emotive Therapy* (Ellis & Greiger, 1977), the chapter on depression is contributed by Aaron Beck and Brian Shaw, who are both more usually associated with Beck's model of depression.

The central tenets of RET can be stated rather simply. Affect is thought to be the result of how a person construes an event rather than to be the result of the event alone. How the event is construed depends upon the person's beliefs about the event. Beliefs may be fairly specific to the event, or they may represent relatively long-standing patterns of thinking.

The beliefs are either rational or irrational. Rational emotive theory maintains that emotive disturbance is the result of the *irrational* beliefs. Irrational beliefs are those beliefs that do not follow, logically, from the facts associated with the event.

Ellis (1977) identifies four main types of irrational belief: 'awfulizing', 'can't-stand-it-is', 'musturbation' and 'damning' of oneself or others. Awfulizing refers to

exaggerating the negative consequences of the event to which the cognition refers. Can't-stand-it-itis refers to cognitions in which it is asserted that the person experiencing the cognition is, or will be, unable to stand the relevant event. Both of these types of irrational belief refer to concepts which Ellis believes are essentially undefined, that is the concepts of 'awful' and being 'unable to stand' something. He believes that persons possess unexamined and virtually superstitious referents for these concepts. The referents are unexamined because the person will not have thought through what 'awful' or being 'unable to stand' something means in terms of actual, physical outcomes. The referents are superstitious because the vague ideas and images that comprise them often refer to experiences that are worse than any which are physically possible.

The third category of irrational belief refers to a set of beliefs that may be interpolated between the event and events of the first two categories. Musturbation refers to a rule or a set of rules for the behaviour of oneself or others. The implication is that if oneself or another person does not behave according to a rule or rules, then it is awful, or one is unable to stand it. In addition, the rules may be impossible or virtually impossible to be complied with, such as 'I/he/she must be perfect'. Ellis believes that the rules are essentially arbitrary standards that the person may have internalised from a number of sources.

The fourth kind of irrational belief, 'damning' refers to making negative judgements about the worth of yourself or others, sometimes as a result of applying the arbitrary standards of musturbation.

Ellis' theory is also applicable to anger. The rules that the offender is seen as flouting are 'shoulds' and are both absolute and often arbitrary.

The parallels between RET and Beck's theory are clear. Both refer to a distorted process of thinking which leads to beliefs that are inconsistent with objective reality. The domains of these beliefs are also very similar: they are concerned with value of self and others and the badness or danger of particular events.

Influences on the program

The influence of Ellis' RET can be discerned in a number of areas. Two of the most important are the 'ABC' pneumonic introduced in Session Two and Ellis' notion that it is the *absoluteness* of the belief that causes problems. The implication of this for the program is that it is not necessary to prove a troublesome belief completely wrong, just to reduce the absoluteness of the belief. This rule is important in the various forms of analysis introduced in Module Three.

McMullin's Cognitive Restructuring Therapy

Much of the theory underlying Cognitive Restructuring Therapy (McMullin & Giles, 1981; McMullin, 1986, 2000) is derived from RET. There are, however, some important differences. McMullin and Giles (1981) contend that cognitions

such as ‘I must be perfect’ and ‘I am worthless’ are neither inherently nor invariably painful. According to McMullin and Giles, the trauma elicited by irrational ideas is itself derived by means of direct or vicarious conditioning. This contention immediately provides a link with therapeutic approaches, such as systematic desensitisation, that are derived from classical conditioning models of emotion. Crucial to the approach of McMullin and Giles (1981) and McMullin (1986) is the idea of ‘countering’, the replacing of the irrational beliefs with directly contradictory rational beliefs. McMullin (1986) states:

> A single theory underlies all cognitive restructuring techniques that employ countering. This theory states that *when a client argues against an irrational thought and does so repeatedly, the irrational thought becomes progressively weaker.* (p 3, italics in original)

This theory is similar to the concept of reciprocal inhibition promulgated by Wolpe in the context of the deconditioning of classically conditioned neurotic anxiety (e.g. Wolpe, 1997). It is based on the principle of retroactive inhibition established by the work of Bunch and Winston (1936) amongst others. Countering is presented explicitly in the program in Sessions Five and Fifteen and although this program does not contain any explicit use of deconditioning procedures, the ‘Difficulties that may be encountered’ sections at the end of each therapy session occasionally refer to the adjunctive use of such procedures in instances when the emotional distress evoked by the procedure presented in the session is too extreme for the participant to deal with using cognitive techniques alone.

Another important element of McMullin’s approach is his analogy of Schemas as being like ambiguous figure drawings such as the well-known old/young woman reproduced in Appendix Six. These figures are initially difficult to interpret but once the images they contain have been recognised it is easy for a person to flip from one to the other of the possible perceptions. Often, focus on detail helps the person to either see the image, or to do the flipping from one image to the other.

McMullin has developed a technique based on this process that he calls ‘Perceptual Shift’. In Perceptual Shift, deliberate focussing on specific positive elements of thought content facilitates positive change in more global thought content. This technique has been used relatively unmodified in Sessions Five and Sixteen and extended for work with imagery, memories and emotion in Sessions Seventeen, Eighteen and Twenty. Another technique developed by McMullin and used in the previous version of the program was ‘Logical Analysis’. In the present program, as already noted, this has been split into two techniques I have called Investigatory Analysis and Scientific Analysis. This is purely to make the technique more able to be understood by participants. The essential logic of Logical Analysis is still embodied in the derived techniques.

Young's Schema Therapy

Young *et al*. (2003) claim that Schema Therapy is 'an innovative, integrative therapy…that significantly expands on traditional cognitive-behavioral treatments and concepts' (p. 1). Young developed the idea that some Schemas developed as a result of toxic childhood experiences and were at the core of many emotional and behavioural problems. He found in his clinical work that there was a limited number of themes to the Schemas that seemed to underlie the emotional and behavioural problems and called them Early Maladaptive Schemas. According to Young *et al*. (2003), an Early Maladaptive Schema is:

- a broad, pervasive theme or pattern;
- comprised of memories, emotions, cognitions and bodily sensations;
- regarding oneself and one's relationship with others;
- developed during childhood or adolescence;
- elaborated throughout one's lifetime;
- dysfunctional to a significant degree (p. 7)

Young sees behaviour as driven by Schemas and as a response to Schemas. He and his co-workers have identified 18 major themes of these Early Maladaptive Schemas, such as Abandonment/instability, Self-sacrifice and Unrelenting Standards. Schemas are triggered by events that are similar to the events in childhood that led to the Schema being developed, which leads the person to suffer strong negative emotion. Behaviour then becomes aimed at reducing the strong negative emotion associated with the Schemas. Young *et al*. hypothesise that the behaviour used to reduce the strong negative emotion can be characterised as three maladaptive coping styles of Avoidance, Overcompensation and Surrender. Avoidance includes avoiding life situations that would trigger the Schema, Overcompensation encompasses attempts to reduce the possibility of the Schema being triggered by behaving contrary to the Schema and Surrender takes a 'better the devil you know' approach by inviting and thereby attempting to control the situations that trigger the Schema.

A number of elements of Young's theory have been incorporated in the theory that underlies this program. The concept of Schemas used is more like Young's than Beck's, but is seen as being *about* an entity or concept as in the Schema *about* oneself, the world and the future. The Schema is seen as having *content*, which includes the memories, emotions, cognitions and bodily sensations referred to by Young, but which also includes propositional material and 'behavioural action tendencies'. The latter have the characteristics and function of Young's coping styles. Schema content is then seen as a balance between positive and negative emotional valence as determined by the content. Similar to Young's conceptualisation, maladaptive Schema content is seen as derived from earlier life experiences some of which is veridical and some of which is based on Logical Errors made at the time.

The addition of some of Young's concepts enriches the theory underlying the program. The main elements influenced are: the theory as presented in Sessions Two, Six and Ten, the non-propositional approaches to cognitive change in Sessions Seventeen to Twenty and the approach to Counterproductive behaviour used in Session Twenty-One. The concept of Schemas used in the program is an extension and blend of Beck's and Young's concepts and is thought to be both parsimonious and appropriate to be conveyed to participants in a psychoeducational program.

The English cognitive therapists

The final influence on the program has been the English cognitive therapists such as Clark, Wells and Salkovskis who have been especially active in extending cognitive models to the anxiety disorders. Their contribution is much too rich to discuss in detail, but it is appropriate to identify a small number of important elements. Three themes of the work of the English cognitive therapists are relevant to this program: the beliefs the sufferer has about the bodily sensation that they are experiencing, the beliefs they have about the strategy they are using to control that sensation and the vicious cyclical nature of these beliefs and strategies. Hence the person with Generalised Anxiety Disorder believes that worry will stop bad things from happening, but then becomes worried that worry itself signifies something bad happening. The person with social anxiety believes that holding their cup firmly will stop their hand shaking so that people won't notice their anxiety, but the increased muscular tension in fact leads to increased shaking and increased anxiety. The person with panic disorder misinterprets their internal sensations as indicating that they are going to die or go mad and so pays increasing attention to their bodily sensations, leading to increased awareness of their uncomfortable internal sensations.

The influence of these and other important contributions of the English cognitive therapists is not in specific therapeutic techniques, but does underlie the models of therapy presented in Sessions Six and Ten and the approach to counterproductive behaviour presented in Session Twenty-Two.

Conclusion

The theory underlying this program is therefore an integration of many of the major trends in cognitive theory over the past 30 years. Elements from the different theories have been used because they are they most parsimonious way of extending the other theories, because they effectively deal with needs encountered in clinical work or because they are more suitable for direct presentation to consumers. The result is a model which is quite simple, but which is internally coherent and applicable to a wide variety of cases encountered in general clinical work. It is therefore appropriate as the basis for a psychoeducational group program. The model itself is presented at various levels of sophistication in the content for Sessions Two, Six and Ten.