The Contemporary Appeal of Cognitive Behaviour Therapy

Paul L. Merrick
Massey University

Frank M. Dattilio
Harvard Medical School

With the approach of the 21st century, revolutionary developments in communication as well as the commonplace use of computers encouraged enquiry into all aspects of our world including the scientific basis for matters affecting health and wellbeing. Not surprisingly, the more popular psychotherapies, sensitive to these social and economic changes in our society and to theoretical developments in psychology, have evolved into more empirically based solution-oriented interventions that have become focused on addressing the more immediate cognitive, emotional and behavioural needs of people. As a result, far less emphasis is now placed, for instance, on force-fitting clients to the doctrines of the rigid pressure-driven hydraulic model of classical psychoanalysis and more towards approaches such as cognitive behaviour therapy that allow for flexibility in their application and direct responsiveness to client distress.

There can be little doubt about the contemporary popularity of cognitive therapy (CT) and more latterly cognitive behaviour therapy (CBT) throughout the western world. In the early 1980s, Norcross and Prochaska started conducting a survey every 10 years that has come to be known as the Delphi Poll (Prochaska & Norcross, 1982; Norcross, Alford & DeMichele, 1992; Norcross, Hedges & Prochaska, 2002). Those surveyed were drawn from among some of the more eminent psychotherapists throughout the world. The poll was designed to attempt to predict future directions in psychotherapy. Initially, the authors predicted that cognitive-behaviour therapy would continue to flourish in the subsequent decade, meaning that increasingly more individuals would favour this particular modality of treatment. In fact, not only did this trend hold true for the decade of the 1980s, but the results have been repeated in the past three polls. Cognitive-behaviour therapy has been ranked first in terms of theoretical orientation across repeated surveys with the anticipation of similar findings in the next decade.

In line with overseas trends, cognitive behaviour therapy was also readily accepted in Aotearoa/ New Zealand among psychological practitioners and consumers (Kazantzis & Deane,1998; Koong Hean Foo & Merrick, 2004).

A number of reasons can be advanced for its popularity among practitioners and consumers. In the first instance, it is very much the product of a diverse array of important theoretical and practical developments in psychology and related disciplines. It is derived from cognitive psychology and behaviour therapy in terms of the development of concepts of schema and cognitive belief. Much of the work of Alfred Adler has been woven into the concept of schema as well as the development of early life views and perceptual experiences. Information processing terminology typical of the work of experimental psychologists is evident in the use of hypothesised processes such as 'filtering' and 'response bias' (Broadbent,1971).The need to focus on one's past in understanding present mechanisms of thought and behaviour, and how they may be expected to respond to future events is reminiscent of classical psychodynamic concerns. Aaron Beck, himself, acknowledges the importance of the writings of Albert Ellis on cognitive distortion and George Kelly's Personal Construct theory (1955) with its emphasis on viewing the world from a clients' emotional and cognitive perspective (Beck, 2005).

Cognitive-behaviour therapy has also embraced part of the Gestalt perspective with regard to an individual's exposure to the environment, its 'present' focus and its impact on thought, emotion, and behaviour. Humanistic existential roots can be found as well in the examination of maladaptive behavioural patterns and distorted dysfunctional schemas. Components of Systems Theory are also utilized, particularly when working with couples and families (Dattilio, 1998).

The integration of significant aspects of contemporary theory and practice has continued throughout its evolution. In a recent article on the comparison of cognitive therapies, Ellis (2003) noted that cognitive-behaviour therapy has now become much more eclectic and integrative and, in addition to a wide variety of

cognitive and behavioural techniques, it also encompasses an increasing number of experiential, interpersonal relationship, existential, humanistic, and other methods. While almost certainly disputed by the majority of cognitive behaviour therapists as an overstatement, Ellis goes so far as to state, "In fact, it (CBT) tends to be so integrative today that it almost belies its original name." (p. 225). As a consequence of drawing on elements from various therapeutic modalities, cognitive behaviour therapy has nevertheless become quite adaptable to different environments. In a world of increasing complexity, psychotherapists need to have a therapeutic armamentarium that is effective with an array of life problems across cultures and life challenges.

Notwithstanding, these influences that have helped to give shape to elements of cognitive behaviour therapy, Beckian Cognitive Therapy has, from its inception, been more than just a random integration or loose collection of theory and therapeutic strategy. A clearly articulated cognitive model of psychopathology was espoused from the outset. Beck's earliest writings outline a plan "(1) to construct a comprehensive theory of psychopathology that articulated well with the psychotherapeutic approach; (2) investigate empirical support for the theory; and (3) to conduct empirical studies that tested the efficacy of the therapy" (Beck, 2005). Beginning with the theory of depression, and in line with the cognitive specificity hypothesis, models for understanding a wide variety of disorders have been advanced and received considerable empirical support (Beck, 2005). Similarly treatment strategies developed specifically for these disorders have been subjected to critical appraisal and scientific validation. For instance, in a search of cognitive behaviour therapy literature from 1967 to 2003, Butler, Chapman, Foreman, & Beck (2006) found 15 methodologically sound meta-analyses covering 9138 participants and 332 studies. This search for scientific rigor almost certainly appeals to modern day consumers who are increasingly knowledgeable about health related matters and quite reasonably request meaningful understandings of their distressing conditions and the use of treatments that have been subjected to empirical validation.

The values inherent in Beck's approach to therapy contained in the term 'Collaborative Empiricism' are also a likely cause of the popular acceptance of cognitive behaviour therapy. Unique to cognitive behaviour therapy, collaborative empiricism encapsulates the notion of a team approach to therapy in which the client collects data in session or as homework to be investigated with the therapist's guidance. Both therapist and client work together as two scientists, defining problems, setting up experiments to test hypotheses and checking ways of solving these problems. The therapist is constantly active through the use of Socratic questioning and guided discovery. This approach is inherently respectful of the client. The explicitness of the process and direction provided by the centrality of a shared individual cognitive conceptualisation of the client's problems provides an ever evolving formulation and road map for treatment thus engendering an important sense of control for the client.

The popularity of contemporary models of cognitive-behaviour therapy in Aotearoa/New Zealand would appear to be based on a number of factors. Foremost among these, is the world wide trend by consumers for professional and economic accountability and "best practice" protocols in psychotherapy as exemplified by the guidelines of the National Institute for Clinical Excellence in the United Kingdom (NICE), (2004). There is a demand from government agencies, the health insurance industry and individual consumers for brief, cost effective solution-based interventions that carry some empirical validation. Today people want to know that when they are embarking on treatment and investing time, money, and emotional energy, there is a reasonable likelihood of treatment success within a relatively brief time frame.. More than any other treatment modality since the advent of modern psychotherapeutic endeavours, cognitive behaviour therapy has demonstrated its ability to empirically address and respond to these demands. Put simply, it has been shown to be effective in reducing symptoms and relapse rates across a wide range of disorders, within a relatively brief period of time, with or without medication (see Hollon & Beck, Ch 10 in Lambert, 2003).

Perhaps it is not surprising given New Zealanders' pragmatic, 'get-on-with-it', 'number 8 fence wire' tradition that, for instance, the prescribed doctrinal tenants of psychoanalytic psychotherapies, the radical instrumental constraints of early S-R 'black box' formulations and the seemingly arrogant and judgmental didacticism of rational-emotive practitioners have not enjoyed popular or lasting support among large sections of the community. Rather, it would seem that a more pragmatic stance is favored that encompasses a variety of different therapeutic modalities and allows for greater therapeutic flexibility, client collaboration and a sense of control.

Further to this, cognitive behaviour therapy's practical perspective assists the therapist with explanations of individual dynamics and this fits into a viable model for treating individuals, as well as couples and families across diverse cultures. Increasingly interest in cognitive behaviour therapy is also being shown by non-western European communities and this is clearly reflected in the popularity of cognitive behaviour therapy focused international congresses and journals which continue to appear each year. Within our own Aotearoa/ New Zealand context the utility and acceptability of cognitive behaviour therapy within Maori conceptions of health and wellbeing and therapeutic practices have received increasing attention (Hirini,1997; Banks, 2002). Considerable work relating to the value of cognitive behaviour therapy is also emerging from Eastern cultures. Its popularity was clearly evident with the staging of over 150 presentations at the "1st Asian Cognitive Behaviour Therapy Conference entitled "Evidence- based Assessment, Theory and treatment" in May 2006 in Hong Kong and organised by the Chinese University of Hong Kong in association with the University of Queensland.

Cognitive behaviour therapy also tends to be time and cost effective and from a practical perspective integrates well with other modes of treatment.

With escalating health costs and hospital budgets that do not allow for psychological therapies to be offered to all but the most severely unwell, as well as a shortage of trained therapists, cost effective treatments assume priority in public health settings. Increasingly those seeking private treatment ask specifically for cognitive behaviour therapy on the basis 'that it works' and is relatively brief and therefore financially viable.

Importantly the biological and physiological underpinnings of anxiety disorders, depression, psychotic illnesses, and other disorders are addressed by cognitive behaviour therapy. A mutual respect exists between cognitive-behavioural therapy and pharmacotherapy because of its short-range goals and the focus on the role of human biochemistry, along with its recognition of the need for the rapid remediation of symptoms. This has become an integral piece in the acceptance of cognitive-behavioural therapy in the fields of medicine and psychiatry (Dattilio, 2003; in press).

Among its most salient contributions, cognitive-behaviour therapy provides a common language for therapists, which is essential, particularly when integrating other psychotherapeutic modalities. The use of a patient's specific vocabulary at times, the use of imagery, or simply everyday language, is especially important when dealing with schemas, scripts, metacognitions, and beliefs.

In essence, cognitive-behaviour therapy takes a common ground approach to intervention, attempting to discern shared elements among diverse theoretical systems. The paradigm highlights those characteristics that are common to all therapies and incorporates them into a unified, harmonious, and multifaceted whole without the loss of its integrity and uniquely defining characteristics. In addition to the carefully selected theoretical practice tools, the cognitive-behavioural model adds in personal experience, personality, knowledge, and clinical acumen as well as cultural sensitivity. In this respect, cognitive-behaviour therapy combines strengths from each area - theory, methodology, and scientific outcome - to create powerful data driven conceptualisations of clients' presentations and a flexible clinical repertoire.

Lastly, cognitive-behaviour therapy reduces the threat of territoriality because it overtly connects with other modalities. The notion of a territorial imperative among psychotherapeutic systems has been suggested as an explanation for resistance to psychotherapy integration (Dattilio, 2002; in review). Since cognitive-behaviour therapists have long interfaced with other modalities, there is little need to protect territorial domain, hence less resistance to integration. On many levels, cognitive-behaviour therapy offers an opportunity for practice that is both open-minded and firmly grounded; a combination that will no doubt lead to improved efficacy of psychosocial treatments in the future.

References

Banks, C. (2002) Using Cognitive Behavioural Therapy with Maori tangata whaiora. *National Maori Psychology Graduates' Symposium: Making a Difference.* University of Waikato.

Beck, A. T. (2005). The current state of cognitive therapy: a 40-year retrospective. *Archives of General Psychiatry,* 62, 953-959.

Broadbent, D. E. (1971) *Decision and Stress.* London: Academic Press.

Butler, A. C., Chapman, J. E., Foreman, E.M., & Beck A.T. (2006). The empirical status of cognitive behaviour therapy: a review of meta-analyses. *Clinical Psychology Review*, 26(1), 17-31.

Dattilio, F. M. (Ed.) (1998). *Case studies in couple and family therapy: Systemic and cognitive perspectives.* New York: Guilford.

Dattilio, F. M. (2002). A bridge and a couple of fences for clinicians and researchers: A comment on Silverman's 2001 editorial. *Psychotherapy*, 39(3), 261-263.

Dattilio, F. M., & Norcross, J. C. (2006) Psychotherapy Integration and the Emergence of Instinctual Territoriality. *Archives of Psychiatry and Psychotherapy 8(1)*, 5-16.

Ellis, A. (2003). Similarities and differences between rational emotive behaviour therapy and cognitive therapy. *Journal of Cognitive Psychotherapy: An International Quarterly*, 17(3), 225-240.

Hirini, P. (1997) He Whakawhiti Nga Whakaaro I te Tangata Whaiora Maori. *New Zealand Journal of Psychology*, 26, 13 -18

Hollon, S. D., & Beck, A.T. (2003) in Lambert, M.J., *Bergin and Garfield's Handbook of Psychotherapy and Behaviour Change: An Empirical Analysis.* 5th Edition, New York NY, Wiley, (Chapter 10).

Kazantzis, N., & Deane, F. P., (1998). Theoretical orientations of New Zealand psychologists: An international comparison. *Journal of Psychotherapy Integration,* 8, 97-113.

Kelly, G. (1955) *The Psychology of Personal Constructs.* New York: Norton.

Koong Hean Foo., & Merrick P. L. (2004) Practitioner characteristics with comparison of counselling and psychotherapy practices between New Zealand and Singapore mental health practitioner. *Proceedings of the Inaugural International Asian Health Conference.*

National Institute for Clinical Excellence. (2004) *Depression: Management of depression in Primary and Secondary Care.* London, England: National Institute for Clinical Excellence; Clinical Guideline 22.

Norcross, J, C., Alford, B. A., & DeMichele, J. T. (1992). The future of psychotherapy: Delphi data and concluding observations. *Psychotherapy,* 29, 150-158.

Norcross, J. C., Hedges, M., & Prochaska, J. O. (2002). The face of 2010: A Delphi poll on the future of psychotherapy. *Professional Psychology: Research and Practice*, 33(3), 316-322.

Prochaska, J. O., & Norcross, J. C. (1982). The future of psychotherapy: A Delphi poll. *Professional Psychology*, 13, 620-627.

Prochaska, J. O., & Norcross, J. C. (2002). *Systems of psychotherapy: A transtheoretical analysis* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Address for correspondence:
Paul L Merrick, PhD
School of Psychology
Massey University, Albany
Private Bag 102 904
North Shore Mail Centre
Auckland

Email: P.L.Merrick@massey.ac.nz