

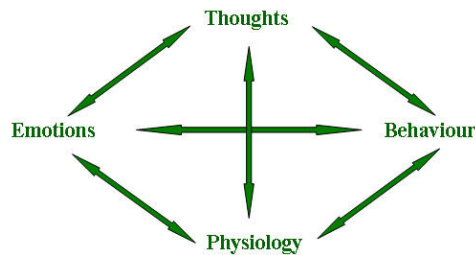
Integrative CBT- Eoin Stephens

The purpose of this article is to describe a model whereby Cognitive Behavioural Therapy (CBT) can be a central part of the ongoing integration of theory and practice in counselling/psychotherapy.

The components of any emerging integration should be, as far as possible, evidence-based and consistent with the findings of scientific psychology. CBT is currently the leading contender in this regard, at least for certain specific diagnoses (depression, anxiety disorders etc), but it is by no means yet a complete theory on its own. Humanistic values such as uniqueness of personal experience, freedom of choice, creativity and authenticity are also vital to any truly caring and growth-promoting therapy. This is not at all inconsistent with the principles of CBT (especially in the Cognitive Therapy tradition informed by the work of Aaron Beck), but it is not always the main emphasis either.

The approach currently forming around the work of integratively-oriented CBT therapists such as myself can be called Integrative CBT, and aims to have both a humanistic and a scientific basis. I present here a tentative model in which Integrative CBT practice can be seen as relating to other therapeutic approaches in a pragmatic way, based on client needs. The following describes the four different levels of therapeutic interaction which need to be kept in mind:

1. Integrative CBT needs to be based first of all on the level of **sound therapeutic relationship**, not just in the sense of a working alliance, but in the sense of taking into account the therapeutic factors which can be provided at the level of genuine human encounter. This level is represented by such approaches as Person-Centred Therapy (Rogers, 1961) and Gestalt Therapy (Perls, 1951). Sometimes this is all a client needs (i.e. space to explore, support, validation, congruence etc).
2. The next level many clients need, in order to create change in their lives, is the level of **practical goal-setting, skill-learning, planning and reviewing** etc. This can be found in the Egan Model (Egan, 2006), Nelson-Jones' Lifeskills Model (Nelson-Jones, 2004), Reality Therapy/Choice Theory (Glasser, 1999) etc. Here we are moving into CBT-style territory, but we are not fully there yet.
3. Even with good quality help at the level just described, many people still find themselves stuck. This especially applies to those with **identifiable mental health issues** such as Depression, OCD, Anorexia etc. This is where CBT proper comes in, based mainly on the cognitive theory and practice of Beck (Beck, 1976; Sanders, & Wills, 2005) and Ellis (Ellis & Dryden, 1999), as well as on behaviour therapy and learning theory. Here we help the client to untangle **self-perpetuating vicious cycles** of cognition, emotion, behaviour and physiology (see figure below), especially by identifying and working to change dysfunctional cognition.



For instance, in a depressed client, their negative thoughts feed their depressed feelings, lack of activity, and exhaustion, and are in turn reinforced by each of these symptoms. Integrative CBT gives attention to all four pieces of this symptom cycle, but is Cognitive-Behavioural in being especially focused on helping the client to make relevant changes in their thinking and in their behaviour, in order to reverse the damaging vicious cycles. Integrative CBT therapists therefore need to become comfortable in working with emotion, behaviour, cognition and physiology.

4. Of course, many clients **need longer-term developmental work**, which can be provided through Schema Therapy etc. Schema Therapy (Young, Klosko & Weishaar, 2003) is itself explicitly integrative in its theory and practice, and indeed emphasises the central role of the therapeutic relationship (through, for example, Limited Re-Parenting) in ways which are reminiscent of the first level of therapeutic interaction described above.

All therapy needs to start at Level 1; how quickly, and how far, it may need to move up the levels depends on many factors, which need to be part of the process of Case Formulation. Case Formulation is defined by Persons (1989, p. 37) as ‘...a hypothesis about the nature of the psychological difficulty (or difficulties) underlying the problems on the patient’s problem list’. In CBT the case formulation is based on the Cognitive Model of emotional disorders, first developed in detail by Beck. As described in Level 3 above, at its simplest level it focuses on Negative Automatic Thoughts which are locked into vicious cycles with dysfunctional emotions, behaviours and somatic symptoms. It can also be expanded, at Level 4, to include more ongoing dysfunctional underlying cognitions in the form of Schemas. In practice, the case formulation guides and structures the course of treatment by unifying and prioritising symptoms, influencing the choice and timing of interventions, and predicting possible problems.

For clients who have a fairly clear mental health diagnosis such as depression etc, Level 3 may be where much of the work happens, but the Integrative CBT therapist may need to return to working at levels 1 and 2 on a frequent basis.

Successful recovery may still leave a need for longer-term developmental work at Level 4, in order to bolster resistance to relapse through addressing underlying Core Beliefs/Schemas.

As regards specific techniques and interventions, CBT is not fully inclusive or exclusive, at least not yet. What I mean by this is that, as it has continued to develop, it has sometimes discarded and sometimes added techniques, on the basis of ongoing research and clinical experience. Some of the techniques which have been added come from other approaches; Mindfulness training is a well-known example (Segal, Williams & Teasdale 2001). This again demonstrates the integrative possibilities of CBT.

In summary, as a way of trying to further capture some of the nature of Integrative CBT, I have taken the Principles of Cognitive Therapy as outlined by Judith Beck, and adapted them in what I feel is a more integrative direction (my additions are in italics):

Principles of Integrative CBT (based on J. Beck, 1995)

- Integrative CBT is based on an ever-evolving formulation of the client and their problems, *primarily in cognitive terms, but also using other well-established theoretical perspectives such as Attachment Theory etc.*
- Integrative CBT requires a sound therapeutic alliance, *based on the Core Conditions of the Person-Centred approach.*
- Integrative CBT emphasises collaboration and active participation.
- Integrative CBT is goal oriented and problem focused, *as necessary.*
- Integrative CBT initially emphasises the present, *also working with the past as necessary, through working with schemas/core beliefs.*
- Integrative CBT is educative, aims to teach the client to be his or her own therapist, and emphasises relapse prevention.
- Integrative CBT aims to be as time limited *as is necessary and possible.*
- Integrative CBT sessions are as structured *as is necessary for the particular client, issue and context.*
- Integrative CBT teaches clients to identify, evaluate and respond to their unhelpful thoughts and beliefs, *and the related emotions, behaviours and physiological responses.*
- Integrative CBT uses a variety of techniques to collaboratively achieve change in thinking, mood, behaviour *and physiology*

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