

During initial sessions, therapists and clients draw up problem lists. Problem lists can consist of specific symptoms, behaviours or pervasive problems. Their function is to assign treatment priorities. Considerations in prioritizing treatment include magnitude of distress, symptom severity, and pervasiveness of theme. Therapists approach each problem by choosing the appropriate cognitive and behavioural techniques to apply. Therapists always offer a rationale for each technique. In addition, both when suggesting and implementing techniques, therapists elicit feedback from clients.

While the early stages of therapy may focus on symptom removal, middle and later stages are more likely to emphasize changing clients' patterns of thinking. Clients are helped to understand the interrelationships between their thoughts, feelings and behaviours. Once they can challenge automatic thoughts that interfere with effective functioning, then they can identify and examine the underlying assumptions or beliefs generating such thoughts. Assumptions may be revealed as themes in automatic thoughts across time and across situations. Once assumptions and core beliefs have been identified and their disruptive power understood, then cognitive therapy aims to assist clients to examine their validity and current usefulness and then discard or amend them, as appropriate.

As cognitive therapy progresses, clients develop their skills of being their own therapists. Clients assume more responsibility for identifying problems, analysing their thinking and creating suitable homework assignments. The role of the therapist shifts from being fairly didactic to facilitating clients as they develop their cognitive self-helping skills. The frequency of sessions decreases as clients become more proficient.

Being mainly a short-term structured approach, cognitive therapy tends to have its ending built into its beginning. Therapy ends when goals are reached and clients feel confident about implementing their new skills. From the outset therapists discuss with clients criteria and expectations for termination. There are a number of ways of assessing progress, including relief from symptoms, changes in reported and observed behaviour, and changes in thinking both inside and outside therapy. Performance in homework assignments, such as filling in the *Daily Record of Automatic Thoughts* log and carrying out specific tasks and experiments, also assists in assessing progress. In particular, therapists look out for clients' ability to reality-test and, if necessary, modify or discard distorted interpretations. Often termination is gradual, say from weekly to biweekly sessions, followed by booster sessions one and two months after termination. The purpose of such sessions is to consolidate gains and assist clients to keep employing their new skills (Beck and Weishaar, 2000).

Cognitive therapy sessions generally last for 45 minutes. The standard treatment length for unipolar depression is eight to sixteen sessions at weekly intervals. Moderately to severely depressed clients may be seen twice a week for the first two or three weeks. Clients with anxiety disorders generally receive from five to fifteen sessions (Clark and Beck, 1988). The treatment of personality disorders generally takes longer and may last for a year or more.

THE THERAPEUTIC RELATIONSHIP

Cognitive therapy is an educational process in which therapists are active in developing relationships with clients and using their expertise in helping clients examine and modify beliefs and behaviour. The quality of the therapist-client relationship is an important medium for improvement. Cognitive therapy is not an impersonal approach, but one in which therapists seek to understand their clients as individuals. Beck regards his therapeutic style as somewhat Rogerian. Therapists strive to create an emotional climate of genuine warmth and non-judgemental acceptance. Furthermore, cognitive therapists give clients their phone numbers in case of emergency.

Cognitive therapists attempt to demystify counselling by using language that clients can understand. They treat clients with respect by offering rationales both for their overall approach and for each technique that they propose. In addition, they share responsibility for what happens in therapy by discussing case conceptualizations and involving clients in setting goals and session agendas. Also, cognitive therapists elicit feedback from clients about both their suggestions and their behaviour. Therapists are sensitive to signs of transference and allow clients' reactions to them to be aired. Therapists can use these transference reactions to identify and work with clients' automatic thoughts and interpersonal distortions.

With most personality-disordered clients, cognitive therapists offer a closer and warmer relationship than in acute disorders, such as anxiety and depression. Therapists can face problems of non-collaboration from clients, especially those with personality disorders (Beck, Freeman *et al.*, 1990).

Serving as co-investigator – collaborative empiricism

In addition to offering accepting and warm relationships, cognitive therapists play an active role in the therapy process. Therapists encourage clients to play an active role too. All of the client's cognitions are viewed as testable hypotheses. Therapists and clients collaborate together in the scientific endeavour of examining the evidence to confirm or negate the client's cognitions. Based on what clients say and how they say it, therapists develop hypotheses that can identify cognitive errors as well as underlying assumptions and beliefs. Therapists then ask clients to comment on whether their hypotheses fit the facts. By this means, clients are encouraged both to view their thoughts as personal views of reality and to build their skills of evaluating their validity. Throughout the process of identifying and exploring the evidence for biased thinking, as appropriate either the therapist or the client takes the more active role.

Serving as a guide – guided discovery

There are a number of different facets to guided discovery. Therapists can operate as

developmental history of the beliefs. Another use of guided discovery is that therapists act as guides in assisting clients to reality-test their possible errors in logic by designing new experiences that involve the client experimenting with different behaviour. Therapists do not use cajoling, disputation and indoctrination to assist clients to reality-test their thinking and adopt new beliefs. Rather, they encourage clients to develop their own skills of using and assessing information, facts and probabilities in order to obtain more realistic perspectives than sometimes offered by their initial thoughts.

THERAPEUTIC INTERVENTIONS

Both cognitive and behavioural interventions are used in cognitive therapy. The interventions selected depend on such factors as the nature of the client's problems, the therapeutic goals, and how well they are functioning.

Cognitive interventions

Following are some of the main cognitive interventions used by cognitive therapists to assist clients to replace their distorted automatic thoughts and beliefs with more realistic ways of processing information.

Eliciting and identifying automatic thoughts

In order to change their thinking, clients need first to become aware of their thought processes. Included below are some specific interventions for eliciting and identifying automatic thoughts.

Providing reasons

Therapists can provide reasons for the importance of examining the connections between how clients think, feel and act. Furthermore, they can introduce the concept of automatic thoughts and provide an example of how underlying perceptions influence feelings. In addition, therapists can communicate that a major assumption of cognitive therapy is that clients are experiencing difficulties in reality-testing the validity of their interpretations. Box 13.3 provides an example of a cognitive therapist showing the relationship between cognition, affect and behaviour (Beck *et al.*, 1979, pp. 147–8).

Questioning

Clients may be questioned about automatic thoughts that occur during upsetting situations. Where clients experience difficulty in recalling thoughts, imagery or role-playing may be used. When questioning, therapists observe clients carefully for signs of affect that may offer leads for further questioning.

BOX 13.3

Example of showing the influence of cognitions on affect and behaviour

The client

A 43-year-old depressed male patient.

The scene

The therapist instructed the client to imagine a person was home alone one night and heard a crash in another room.

Interpretation 1

This person thinks 'There's a burglar in the room.'

Possible consequences of interpretation 1

The therapist then asked the client:

- 'How do you think this person would feel?', to which the client answered 'Very anxious, terrified.'
- 'And how might he behave?', to which the client replied he might hide or phone the police.

Interpretation 2

The therapist then instructed the client to imagine that the person heard the same noise and thought: 'The windows have been left open and the wind has caused something to fall over.'

Possible consequences of interpretation 2

The therapist then asked the client:

- 'How would he feel?', to which the client replied the person wouldn't be afraid, though he might be sad if he thought something valuable had been broken.
- 'And would his behaviour be different following this thought?', to which the client replied it would be different in that he would probably go and see what the problem was and certainly wouldn't phone the police.

Main teaching points

The therapist emphasized that this example showed:

- that usually there were a number of ways the client could interpret a situation, and
- the way he interpreted a situation would affect how he felt and behaved.

Encouraging clients to engage in feared activities

Frequently, during sessions, clients are encouraged to engage in anxiety-evoking activities: for instance, making phone calls or writing letters they had been putting off. As they