

Keynotes

Behavioural-cognitive psychotherapy training for psychiatrists

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“The therapist can cite Bertrand Russell’s observation that the degree of certainty with which one holds a belief is inversely related to the truth of that belief. Fanatics are true believers, scientists are sceptics”. (Beck *et al*, 1979)

I propose to describe the evolution of behavioural treatments, and the more recent leap forward made by cognitive therapy. Exciting new treatments are now available that did not exist when I was a trainee. The accepted term for these treatments is “behavioural-cognitive psychotherapy” (BCPT). They are behavioural in the sense that emphasis is on observable behaviour, e.g. avoidance of supermarkets in agoraphobia. They are cognitive because many approaches involve working with patients’ thoughts, e.g. the negative thinking of depressed patients. The treatment is psychotherapy as it is therapy that works at the mind level, rather than at say the synaptic level as pharmacotherapy does. BCPT combines well with pharmacotherapy, and other therapeutic methods such as social therapy, and so is suitable for a multidisciplinary approach to a psychiatric problem, as well as offering specific techniques for identified disorders.

The question as to who should carry out these treatments is debatable. I put forward arguments as to why it is essential for psychiatrists to have a training in BCPT as it offers a flexible formulation-creating framework for most psychiatric disorders. There is evidence that BCPT methods are applicable directly to 60% of patients presenting to psychiatric out-patients. Here there is great need for working with psychologists, and nurse-therapists and others, but this does not abnegate the value of consultant psychiatrists being trained in these methods if they are to be leaders of multidisciplinary teams. If they are not so trained, I argue that they fall seriously behind in therapeutic skills. They are in danger of becoming back seat drivers of the worst kind: those who do not know how to drive! Or to pursue the transport metaphor, they are still riding horses in the age of the motor car.

A further strength of BCPT is that it has carefully and scientifically evaluated treatment effects as new therapies were developed. It also encourages

evaluation, e.g. by the use of measures, written treatment plans, definable goals, and feedback on each treatment occasion. In other words audit and research are built in to the approaches.

Finally, the article addresses a manpower crisis. Unless urgent recognition is given to BCPT in training psychiatrists in the UK, there will not be enough expertise at consultant level for these methods to be widely available.

The evolution of behavioural treatments

In the early 1950s Wolpe was popularising systematic desensitisation. There have been a large number of studies of systematic desensitisation (SD), notably that of Gelder *et al* (1967) which compared SD with individual psychotherapy and with group psychotherapy in patients with phobic disorders. SD was consistently better than either form of psychotherapy. Despite its effectiveness, SD was a slow and time-consuming treatment which stimulated a search for a quicker and more effective approach.

This replacement was found with in vivo exposure methods which were pioneered with specific phobias and caused a sensation when first reported.

Studies of exposure treatment for agoraphobia were then carried out, and the treatment was found to be effective. The treatment of obsessive-compulsive disorder (OCD) was developed at the same time as that for agoraphobia. Marks *et al*. (1975) reported the results over two years of 20 patients with chronic obsessive rituals treated by real life exposure. This treatment was as effective for obsessive rituals as it was for agoraphobia, although in patients with rituals it was often combined with modelling and response prevention.

Cognitive therapy – the leap forward

Beck’s work suggested a way of helping neurotic patients without requiring the postulation of the unconscious. He made the revolutionary step of stating that psychological problems could result

from commonplace processes such as faulty learning, making incorrect inferences on the basis of inadequate or incorrect information, and not distinguishing adequately between imagination and reality. The therapeutic implication was that problems could be mastered by sharpening discriminations, correcting misconceptions, and learning more adaptive attitudes.

In Beck's model there are two mechanisms that produce depression: the cognitive triad and errors in logic. The cognitive triad consists of three major cognitive patterns. The first of these is the patient's negative view of himself. He/she sees him/herself as inadequate, diseased and deprived. The second component is the depressed person's tendency to interpret ongoing experiences in a negative way. The third component is a tendency to take a negative view of the future: when he/she considers a task he expects to fail, and he/she anticipates that suffering and difficulty will continue forever.

Beck's model describes "errors in logic" which fall into several categories. They are generally followed by negative automatic thoughts. Learning how to identify negative automatic thoughts and deal with the errors in logic is at the heart of cognitive therapy for depression. Negative automatic thoughts are thoughts that "pop into the head", that is they are difficult to control, and are plausible to the patient, hence difficult to challenge. They occur to a whole range of stimuli, so that patients develop a set of negative responses to everything and everybody around them often including the therapist. Once a negative thought enters the head it cannot easily be dismissed, in this way having similarities to obsessive thoughts.

The radical views of Beck and also of Ellis led to the development of BCPT for the two very common clinical problems of depression and anxiety disorders. There are existing treatments for these conditions with medication, but evidence is now emerging that the combination of BCPT with antidepressant medication prevents the relapse of depression. BCPT for anxiety disorders provides an alternative to tranquilliser prescription with its attendant problems of dependency.

Wider applications

BCPT has now been applied to diverse conditions. Its application to schizophrenia goes back to the 1960s when Ayllon & Azrin (1968) applied operant reinforcement principles to produce changes in patients with chronic schizophrenia. Nowadays BCPT is used to counteract the secondary handicaps of schizophrenia and to assist in patients discharged from hospital to the community.

In 1970 the pioneering work of Masters & Johnson led to a range of behavioural techniques for sexual

TABLE I
Applications of behavioural-cognitive psychotherapy (BCPT)

<i>Disorder</i>	<i>Level of application</i>
Phobic disorders including agoraphobia	M
Obsessive-compulsive disorder	M
Anxiety and panic disorder	M
Marital/family discord	M or S
Schizophrenia	S
Depressive illness	M
Somatic disorders and hypochondriasis	M
Addictive problems including alcohol misuse	S
Eating disorders	M or S
Personality disorders	S

KEY: M = BCPT is the MAIN indicated therapy, S = BCPT is a SECONDARY therapy often of value in a multidisciplinary setting.

dysfunction. Crowe & Ridley (1990) reviewed the use of BCPT in marital and sexual dysfunction. There remain a number of other conditions where the application of BCPT has been fruitful, e.g. habit disorders such as tics, and other pathological behaviours. Special mention should be made of "behavioural medicine", an expanding field where BCPT is applied to somatic disorders such as irritable bowel syndrome, resistant asthma, hypertension and many other conditions in medicine where psychological factors loom large (Stern & Drummond, 1991). In addition, other conditions at the interface of medicine and psychiatry prove amenable to BCPT: eating disorders, sleep disorders, alcohol misuse. There has been a recent move to apply BCPT to personality disorders (Beck & Freeman, 1990), and there is a trend now for BCPT to be used for an increasing range of disorders (see Table I).

The current situation

The time is now ripe to integrate behavioural and cognitive approaches. It makes sense to incorporate cognitive approaches into behavioural ones, especially where a pure behavioural treatment is not at first effective or where one is lacking – for instance in the treatment of generalised anxiety states. On the other hand, exposure therapy is effective in most cases of phobic disorder; so there is really no need to invoke the more time-consuming cognitive approaches those trained in a "pure" cognitive school might advocate. It is a common sense notion to put behavioural treatment with cognitive treatment to produce BCPT.

Many see BCPT as ignoring the complexities of the human relationship, as reductionistic, and

too superficial or even debasing. However, the techniques described are meant to be applied in a sensitive manner in which the therapist acts as “guide” assisting the patient to overcome difficulties. The treatments are goal directed and to this extent are reductionistic, but they are the goals the patient (the consumer of the service) wishes to achieve, and are arrived at by mutual consent. The therapist requires the humility to recognise that he can only achieve limited goals, and these only if the patient works with him. The criticism that BCPT methods are ‘too superficial’ implies that there are more ‘underlying’ aspects too subtle to be unearthed by these crude methods, and moreover new symptoms waiting to emerge—the so called “symptom substitution theory”. This theory is just not supported by the evidence. As to the criticism that the techniques are debasing: what is actually done is to offer a treatment that aims to provide a set of tools for the patient to be self-reliant. He is given the responsibility for the treatment and expected to work at it outside the consultation room. One aim is to create self-reliance and to avoid “dependence” on the therapist, and another is to avoid dependence on medication.

Increased demand

“The initial power of the therapist as a controlling agent arises from the fact that the condition of the patient is aversive and that any relief or promise of relief is therefore positively reinforcing” (Skinner, 1953). These remarks by the author of the controversial book *Science and Human Behaviour* lead us to speculate why therapists have turned to BCPT in the first place, and how BCPT may differ from those of traditional psychotherapy. In traditional psychotherapy the therapist does not criticise the patient or object to his/her behaviour in any way. In BCPT there are carefully defined goals and objectives which are agreed upon between patient and therapist, and the therapist may strongly object if treatment contracts are broken.

The reasons for this are to do with a revolution in the theory behind “neurotic” disorders and the failure of traditional theories to solve the problems of therapy. BCPT requires drastic retooling for most traditional therapists: it is up to the caring professionals to consider the scientific alternatives, but in these days of purchaser/provider provision of services the remarks of Strupp & Hadley (1977) are ever more pertinent:

“In the final analysis, how a treatment result is to be judged is an issue of human values and public policy, not of empirical research. As insurance companies and taxpayers begin to foot the bill, issues of treatment have become translated into issues of accountability, in terms the public can understand.”

The incentives towards lowering cost of care, and providing evidence for cost-effectiveness are factors where behavioural-cognitive therapists have led the field. Studies of group treatments for agoraphobia, and other ways such as an emphasis on self-therapy, the use of manuals and on homework exercises to increase cost effectiveness have been cited. In my own work with cognitive therapy for hypochondriasis, this was effectively carried out in a group setting. I have found that in the cognitive therapy of depression it is usually not necessary to carry out 20 sessions each of an hour’s duration as advocated by Beck.

The problem of training

Should psychiatrists give psychological treatment and are they equipped to do so? Psychiatrists have a useful basic training in biological sciences. Medical training encourages communication and interview skills. We have more sophisticated models of illness-behaviour than physicians, but our medical training gives us an understanding of disease processes, and also of psychopharmacology that psychologists lack.

There are other reasons why it is imperative to keep abreast of new psychological treatments. One has to do with the failure of traditional psychotherapy to address the major problems of psychiatric illness. The other reason is that the rapid development of psychotropic drugs since the 1950s has not brought about the answer to many psychiatric ills.

On the other hand, there has been an impressive development in behavioural and cognitive therapies for a wide range of conditions, and this sudden expansion in psychological therapy has posed a problem to those involved in education. It requires humility to learn from younger colleagues and to attend workshops to acquire new methods. After this phase there has to be a period of carrying out the new techniques in one’s own clinical practice. Thirdly, the methods have to be taught and supervised and in turn to be put into practice.

BCPT requires drastic retooling for most traditional therapists and what would be the implications of a failure to do this? Psychiatrists are left with their traditional roles of descriptive psychopathology, and dispensers of medication. Some would say this is what they do best and they should stick to their lathes. They could also decide to become traditional psychotherapists and many take this route. Of the 114 consultant psychotherapists in this country, only two specialise in behavioural-cognitive psychotherapy.

If psychiatrists are not trained in BCPT it leaves them therapeutically impotent, and therefore less able to lead a multidisciplinary team. Nurses have already been successfully taught these skills, and many psychologists are waiting in the wings in this country

but are already therapeutically active in the USA. Finally, what role can the College take in all this? In order to supervise trainees in these methods, more consultants are needed with a background in general psychiatry and experience in BCPT. In order to provide these consultants for the future, senior registrar posts are urgently required with specialist training in BCPT if our profession is to move with the times.

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The Social State

A proposed new element in the standard psychiatric assessment

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As psychiatry broadens its perspective beyond a predominantly hospital focus, the tools of its trade need some reshaping to serve the needs of an altered working environment. The instrument indispensable to every psychiatrist is the scheme for assessment, comprising history-taking and examination of the mental (and physical) state. Honed by long familiarity and usage, its employment is the fundamental skill demanded of aspirants to medical practice and to psychiatry.

In this article we identify one way in which the scheme for assessment falls short of present-day requirements, and we suggest a remedy. We aim to stimulate debate and, more ambitiously, to introduce modifications of sufficient value to be incorporated into everyday practice and teaching.

A need for change

Today, the most severe weakness of the assessment scheme is that it gives inadequate emphasis to the social dimension in history-taking and assessment. The inadequacy is particularly evident in domiciliary settings and in multidisciplinary team-work and rehabilitation, but it is becoming more evident in acute hospital psychiatry, too, with increasing awareness of the continuity of the patient's life outside hospital. The need for such awareness is emphasised in new directions in policy, such as the White Paper on community care (Department of Health, 1989) and the Royal College of Psychiatrists' (1989) guidelines for aftercare.