Cognitive Behavioural Therapy

CORE INFORMATION DOCUMENT

MARCH 2007

BRITISH COLUMBIA
Ministry of Health

CARMHA Centre for Applied Research in Mental Health and Addiction
Faculty of Health Sciences
Simon Fraser University

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Library and Archives Canada Cataloguing in Publication Data
Somers, Julian.
Cognitive behavioural therapy [electronic resource]

"The Core information document on cognitive-behavioural therapy was developed by the Centre for Applied Research in Mental Health and Addiction (CARMHA) at Simon Fraser University under the direction of the Mental Health and Addiction Branch, Ministry of Health"—P. i.
"Principal author: Julian Somers ; contributing author: Matthew Querée"
Available also on the Internet.
ISBN 0-7726-5598-7

1. Cognitive therapy. 2. Mental illness – Treatment. 3. Mental illness - Bibliography. I. Querée, Matthew. II. British Columbia. Mental Health and Addictions. III. Simon Fraser University. Centre for Applied Research in Mental Health and Addictions. IV. British Columbia. Ministry of Health.

RC489.C63S65 2006 616.89'14209711 C2006-960147-X

Disclaimer

Research in the medical and behavioural sciences and information about cognitive behavioural therapy and pharmacological treatments for mental disorders and addictions is rapidly changing. Furthermore, medical and health concerns are unique to each individual and require individual attention and care. Accordingly, it is recommended that you consult with your physician and a qualified cognitive behavioural practitioner before acting on any of the information in this book.

Core Information Document on Cognitive-Behavioural Therapy

The Core Information Document on Cognitive-Behavioural Therapy was developed by the Centre for Applied Research in Mental Health and Addictions (CARMHA) at the Simon Fraser University under the direction of the Mental Health and Addictions Branch, Ministry of Health, Government of British Columbia. This document is part of a number of best practice documents released by government to support high quality mental health and addictions care in the province.

NOTE: The terms cognitive behavioural therapy, cognitive-behaviour therapy, and cognitive-behavioural therapy are synonymous and used interchangeably throughout this document.

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CHAPTER 1 Introduction to the Core Information Document

The Need for a "Core Information Document"

Cognitive-behavioural therapy (CBT) holds a unique status in the field of mental health – CBT is effective for many psychological problems, is relatively brief, and is well received by individuals. A large volume of research has been published regarding CBT, including a number of well-designed studies involving people in "real world" clinical settings. Yet despite this large base of evidence, information about CBT has not been well communicated to consumers, families, and providers of health care. Consequently, CBT is not being used as extensively as the research would warrant.

Many individuals (consumers, families, and professionals alike) are unaware of the effectiveness of CBT for different problems. There is additional uncertainty about the effectiveness of different formats of CBT (for example, individual, group or self-help formats), who can provide CBT, how to access their services, and other treatments with which CBT is used (for example, the use of medication and CBT together). This Core Information Document has been assembled for the benefit of individuals, families and service providers interested in a broad summary of information relating to CBT and its effectiveness.

CBT is attracting increasing levels of interest from health care professionals, consumers and families. A variety of factors may contribute to this rise in popularity. First, recent decades have seen a growing recognition of the high prevalence rates of many psychological problems. Mental disorders negatively affect the quality of life for the person as well as his or her family. Many of these disorders (including depression, anxiety, and alcohol problems) have been shown to respond well to CBT. Second, we face increased demands for efficient and cost-effective health care services. CBT has the benefits of being structured, effective and, in most cases, relatively brief. Third, people are increasingly interested in alternatives to medications. In some cases, CBT represents a proven, and sometimes superior, alternative to medication. In other cases, CBT is a beneficial addition to medication, hastening improvement and helping to maintain improvements over time. Fourth, CBT models "consumer-focused care", in which practitioners and individuals work together to build the tools individuals need to make changes necessary to living

better. Fifth, the strategies and skills of CBT can be applied to many of life's challenges. The strategies and skills a person acquires to manage depression, for example, can also be used to manage chronic pain, control drinking or maintain exercise. The effectiveness of CBT in changing and maintaining changes in behaviour makes it very important to consumers and to health care services.

A Resource for Various Readers

Interest in CBT has been expressed among diverse groups in British Columbia, including policy makers, health administrators, health service providers who are non-specialists in mental health, as well as consumers and their families. This *Core Information Document* is offered as a resource to each of these groups. There is a vast literature relating to CBT, including books, articles and internet resources. This document provides a brief overview of CBT and summarizes evidence supporting the effectiveness of CBT for a variety of psychological problems.

Many resources relating to CBT appear throughout the text, including web and print based resources for consumers, educational resources for health care professionals, and sources of further information for interested readers. Most of the information has been organized around the diagnostic labels used in the *International Classification of Diseases*[1] and the *Diagnostic and Statistical Manual*[2] *(Fourth Edition - Text Revision)*. The layout of the Core Information Document is intended to serve as a convenient reference to clinicians, consumers and family members who are interested in the application of CBT for a particular type of problem. Vignettes (hypothetical) are provided to briefly illustrate the types of psychological problems considered in each chapter. Diagnostic criteria are provided as well, representing the formal definitions used in research on CBT.

CHAPTER 1 Introduction to the Core Information Document

What is CBT?

CBT is a psychological treatment that addresses the interactions between how we think, feel and behave. It is usually time-limited (approximately 10-20 sessions), focuses on current problems and follows a structured style of intervention. The development and administration of CBT have been closely guided by research. Evidence now supports the effectiveness of CBT for many common mental disorders. For some disorders, carefully designed research has led international expert consensus panels to identify CBT as the current "treatment of choice".

CBT is less like a single intervention and more like a family of treatments and practices. Practitioners of CBT may emphasize different aspects of treatment (cognitive, emotional, or behavioural) based on the training of the practitioner. Nevertheless, the identified techniques of CBT prove their family resemblance in a number of ways. All techniques and approaches to CBT are practically applied. What gets used (that is, which technique for which problem) is what has been proven effective and the techniques themselves derive from science (for example, the 'behavioural experiments' used to help people overcome feared objects or situations). CBT has been studied and effectively implemented with persons who have multiple and complex needs, and who may be receiving additional forms of treatment, or have had no success with other kinds of treatment.

Forms of CBT

CBT continues to evolve with different formats and emphases as research support emerges. The majority of evidence supporting CBT is drawn from studies involving expert practitioners working with individuals over a specified number of sessions (for example, between 10 and 20 one-hour sessions). A smaller number of studies supports the effectiveness of CBT when administered in groups. The principles of CBT have also been incorporated in some self-directed resources (for example, self-help books, computer programs). Together, these interventions represent an emerging continuum or range of steps to the delivery of CBT. Individuals who do not respond to an initial step, for example "bibliotherapy", could be redirected to a facilitated self-care program, group CBT, or one-on-one CBT as needed. Treatment planning and selection of procedures are based on discussion and judgment of health service providers trained in CBT and involved in the care.

Who Provides CBT?

The appropriate and effective use of CBT presumes the practitioner is a qualified health practitioner with training in assessment and treatment of mental health problems and specific training in CBT. The general clinical skills required of the practitioner include the abilities to establish a collaborative therapeutic alliance, to assess and address complications of mental disorders (for example, risk of suicide in depression) and to conduct a differential diagnosis of mental disorders. All CBT work, no matter the specific treatment or technique, begins with a careful assessment of the person's clinical disorder(s). Diagnosis is necessary in order to determine which, if any, of the CBT techniques are best suited for a particular individual.

Clinical Training in CBT

Clinical training in CBT involves both instruction and supervised clinical experience. Training in CBT is typically available in doctoral programs of clinical psychology. The Canadian Psychological Association and the American Psychological Association each accredit university-based doctoral programs as well as internships operated most often by hospitals, psychological service centres or community health centres. Both accrediting bodies mandate the use of evidence-based treatments, most commonly CBT. Provincial and territorial regulatory bodies license psychologists, like other health care practitioners in Canada. Regulatory bodies hold their member psychologists accountable to meeting and maintaining standards of practice.

Beck and colleagues (1979) were among the first to emphasize the need for intensive training in CBT.[3] Training in CBT is available to practicing or regulated health care professionals who wish to extend their scope of practice. This training is provided through fellowships at universities and through private training centres. Admission to this type of training is typically restricted to professionals who already possess the general clinical skills referred to earlier in this chapter. Training is then provided through a balance of on-site classroom or online instruction interspersed with clinical supervision (typically not less than one hour per week). While there is no consensus about how much or how long a practitioner must train to deliver CBT competently, the process of developing competency in CBT often lasts 12 months for established mental health service providers (regardless of whether the training is provided through a public or private institution). Once training is completed, the practitioner must also remain up-to-date with new developments in the research and practice of CBT.

Demand for CBT exceeds the supply of health care professionals who are trained and qualified to provide it. Current research is looking at ways to make treatment more accessible to those who need it. Health care practitioners and their professional associations are also working with governments to improve the accessibility of these evidence-based services to Canadians. As these developments proceed, documents like this one can help improve understanding and awareness of CBT, and serve as a link to effective resources and care.

CHAPTER 2 What is Cognitive-Behavioural Therapy (CBT)?

CBT is a process of teaching, coaching, and reinforcing positive behaviours. CBT helps people to identify cognitive patterns or thoughts and emotions that are linked with behaviours.

James had always thought of himself as a worrier but he had never experienced psychiatric illness.

However, at the age of 43, James lost his job as a car mechanic and developed depression over the following months. He began to feel very little pleasure out of his daily activities, many of which he had given up. He felt tired most of the day, had difficulty concentrating and slept for over 12 hours a night. As his symptoms became worse, he became increasingly worried that he may have an incurable brain disease. He visited his general practitioner who was unable to find any evidence of a physical problem. Instead, she recognized the symptoms of depression immediately. James tentatively accepted the diagnosis and asked how he could be helped. The doctor explained how a course of CBT with a trained CBT practitioner might be a good option. She explained to him that there was good evidence that CBT could help people with his level of symptoms, but if he was unsatisfied after the course of CBT, he could then try a course of antidepressants. He agreed and the CBT practitioner was able to meet him for an assessment three weeks later.

1.0 Thinking

Different people can think differently about the same event. The way in which we think about an event influences how we feel and how we act. A classic example is that when looking at a glass of water filled halfway, one person will see it half empty and feel discouraged and the other sees it half full and feels optimistic. People do not have to continue to think about their experiences in the same way for their entire lives. By identifying dysfunctional thoughts and by learning to think differently about their experiences, people can feel differently about these experiences, and in turn, behave differently.

Most of the time people believe things about themselves and the people around them because they have good evidence for their beliefs. However, people are often very selective in the evidence that they focus on (or what they believe to be "fact"). A depressed individual may remember the person who ignored her in a conversation but not remember the person who found her interesting. Therefore, she may conclude, "I am a boring person". Cognitive-behavioural practitioners help people understand how, by selecting particular evidence to focus on, they can end up forming beliefs that are 'cognitive distortions'. The individual may not even be aware that they have formed these beliefs. Such cognitive distortions are problematic, not only because they can be inaccurate, but also because they contribute (more than necessary) to debilitating negative emotions or avoidance of troubling situations. People can learn to recognize their automatic thoughts, monitor and scrutinize these thoughts, and pay attention to evidence that supports alternative beliefs (for example, "Some people find me pleasant and interesting to talk to").

CHAPTER 2 What is Cognitive-Behavioural Therapy (CBT)?

2.0 Behaviour

What we do affects how we feel and think. The individual, who deals with an upcoming exam by putting off his studies until the last minute, is likely to experience more distress on the day of the exam than an individual who has studied well in advance. CBT helps people to learn new behaviours and new ways of coping with events, often involving the learning of particular skills.

An example is the development of social skills. Poor social skills can lead to a lack of support and less ability to deal with problematic situations, such as criticism or intimacy. Success in social situations may also be key in developing self-esteem and focusing on performing activities as laid out in CBT sessions.

Emphasizing behavioural change may also be important to fear reduction. Avoidance is a central feature of anxiety disorders. Unfortunately, avoidance can further the fear of anxious situations, and can place severe limits on an individual's ability to freely engage in a full range of daily activities. Exposing individuals to fearful situations gradually and safely (for example, in the practitioner's office) is a primary means of weakening the link between a feared situation and the anxious symptoms it triggers.

3.0 The Therapy

Besides its special focus on the relationships between how we think, feel and behave, the following are fundamental to the practice of CBT.

3.1 Qualities of the Therapeutic Relationship

The relationship between a qualified CBT practitioner and individual seeking treatment is collaborative. They work together to try to understand the person's difficulties and what may be contributing to them. The practitioner is an expert on CBT whereas the individual is an expert on her own life and experiences. During therapy, both of them work together to generate and try out new ways for the person to think and behave. In CBT, the therapeutic relationship is sometimes seen as one of "coaching"; the practitioner uses his/her expertise to challenge the person's thinking and guide them to explore various alternatives.

3.2 Goal-setting

After identifying the individual's problems, it is important for the qualified CBT practitioner and individual to set goals together to deal with these problems. For example, a depressed person who experiences anxiety in public places may identify small goals (such as, leaving the house 1-2 more times per week) in order to gradually reduce her anxiety and feel more comfortable in public.

3.3 Focus on the Present

The past cannot be changed, but the way we think about the past can be (as can the present and the future!). It is often distress in the present and hope for the future that lead an individual into treatment. CBT is focused mainly on what the individual feels and how she is coping in the present. However, feelings and behaviour are often determined by past experiences. For example, the present focus for the individual described in the goal-setting section would be the beliefs and fears she has about going out in public. In addressing and changing her beliefs about being out in public, she may recall a past public situation(s) which was frightening (for example, "I saw someone have their purse snatched on the subway") or an experience that was related in some way to the development of her fear (for example, "My parents continually talked about how the streets were unsafe and they would not let me go out alone until I was 18"). The individual in this

example may also find it helpful to recognize that her fears might have made sense in light of some of her earlier experiences but, over time, have ceased to be helpful. In talking about her fears, and the factors that brought them on and now maintain them, she can experiment with alternate beliefs (for example, people are rarely robbed on subways; my friends travel safely on the city streets) and new behaviours (for example, going downtown) to feel differently (for example, "I am less afraid knowing that, with planning, I can go downtown safely on my own").

3.4 Structure

The sessions of CBT are typically one hour in length, are structured by an agenda, and are often pre-determined in number (for example, the qualified CBT practitioner and individual contract for 10 one hour sessions, and the individual is informed about issues such as confidentiality and any risks associated with engaging in CBT). At the start of each session (or in preparation for the next session), the qualified CBT practitioner and individual seeking treatment draw up an agenda of what topics they plan to cover and then attempt to work through them systematically. Between-session practice is also structured, as are future expectations, to achieve specific goals the person in treatment desires. The use of structure promotes accountability, organization, and ultimately, progress in treatment.

3.5 The Formulation

With the help of the individual seeking treatment, the qualified CBT practitioner puts together a model of the individual's problems and what may be contributing to them. This model, called a 'formulation', is often developed with the use of records or logs the individual fills out. The logs might ask the person to keep track of beliefs he has (for example, "I am boring"), the feelings associated with the belief (for example, "I feel unloved"), the evidence he has for the belief (for example, "I don't have as many friends as my brother which means that people don't find me interesting") and alternate evidence (for example, "I do have a few close friends who want to see me regularly so they must find me fun to be with").

The logs can chart thoughts, feelings, behaviours, bodily changes, events and other people's behaviour. The formulation looks to the links among these elements to explain what keeps a problem going (other elements such as past experience, are also considered). For example, in an individual with paranoia, being looked at by a stranger (other's behaviour) may trigger the *thought*, "He is going to attack me", which leads the individual to run away immediately (*behaviour*). If the individual runs away every time he sees a stranger look at him, he will never find out that the stranger would actually pass him by, and so he remains afraid. Part of the therapy would involve helping the individual to look at strangers, despite his fear. After looking at several strangers who do not attack him, he will gradually realize that his thought or belief about strangers is unfounded. There can be several formulations if the individual has more than one problem (for example, depression and a fear of going out in public). Formulations can change as the individual presents new information and experiences through the course of treatment.

3.6 Relapse Prevention

As mentioned, CBT is time-limited. Although the number of sessions is often pre-determined, they can be negotiable depending on the practitioner, the nature of the person's problem and evolving life events. Treatment is designed to help prevent future relapses. It aims to better equip people with the skills they will need to face future problems on their own or with supports.

3.7 Principles

CBT can be considered to have several main principles.[1] These principles are that the therapy:

- Is based on the cognitive-behavioural model of emotional disorders (for example, thoughts influence feelings and behaviour);
- Is brief and time-limited;
- Requires a sound therapeutic relationship and is a collaborative effort between the qualified CBT practitioner and the individual seeking treatment;
- Individuals are guided to discover new ways of thinking for themselves with specific questions;
- Is structured, directive, and problem-oriented;
- Is often based on an education model (for example, explaining the effects of perceiving threat on bodily reactions);
- Relies on the inductive method, a scientific approach using logic and reasoning; and
- Uses between-session practice as a central feature (for people to put into practice what they have learned). New behaviours are initially tested in safe situations (for example, the practitioner's office).

The CBT practitioner offered James 12 sessions of CBT for depression. In the first session, she described to him the nature of depression, explaining that it is a real illness but that reduced activity and certain styles of thinking were thought to make the symptoms worse. In the second session, the practitioner drew a formulation of James' depression. She asked him to comment on the formulation and add his own elements. James broadly accepted the model, but he also believed that the poor workings of his brain would lead him to fail at anything he attempted which would make him more depressed, and so this was added to the formulation. From session three, the practitioner asked James to keep a diary of his activities and to record which ones gave him a feeling of pleasure and achievement. After doing this for several weeks, James began to notice that his mood would improve if he began to return to his previous activities, but he was still convinced that he would fail at any real job. In session seven, the practitioner suggested an alternative belief, "I can manage to return to work without failing if I take things a bit at a time". James was able to provide some evidence for this belief: a previous colleague had returned to work by starting part-time, and he remembered that his own apprenticeship after leaving school had been a gradual process. They agreed to test this alternative belief. Luckily, James was able to arrange casual work through a contact. James often felt that he would fail when taking on these new jobs, but the practitioner helped him to question the distorted negative thoughts about work and find evidence to support more adaptive positive beliefs. His symptoms of depression gradually subsided. During the last two sessions some of the depressive symptoms re-emerged and James more readily challenged negative beliefs, and continued with his newly scheduled activities.

CHAPTER 3 Depression

Jane developed symptoms of depression after a series of stressful life events.

She was involved in an abusive marriage and a painful divorce. She was unable to cope at work and subsequently lost her job as an advertising executive. Without her routine of work, she began to spend more and more time at home, where she would dwell and ruminate on her failures in love and work. She became less active, tired most of the day and her mood deteriorated. She began to believe that her brain had changed irreversibly as a consequence of her depression and she started to avoid seeing her friends for fear that they would look down on her for not being able to cope. Her medical doctor prescribed antidepressants, which she felt 'took the edge off her depression' but her symptoms still prevented her from going out or returning to work.

CHAPTER 3 Depression

The psychiatrist, Aaron T. Beck, developed cognitive therapy in the 1960s to treat depression.[1] Up until that time, most psychotherapy for depression had its origins in the psychodynamic approach inspired by the work of Sigmund Freud.[2] The first controlled outcome study of cognitive-behaviour therapy (CBT) for depression was conducted in 1977 and since then a great deal of research into the effectiveness of CBT, across a range of treatment settings and populations, has been conducted. Currently, CBT is in common use throughout the world, within public and private health care services, and particularly in the US, Canada, the UK, Australia and Northern Europe. CBT for depression is administered either on its own or in combination with medication.

1.0 The Content of the Therapy

CBT, as applied to depression, relies on all of the key principles of CBT, in that it is collaborative, present-oriented, and problem-focused. Typically, the treatment involves:

- Helping the person in treatment to establish daily activities to provide structure and direction in graduated steps;
- Encouraging the person to identify and challenge negative thoughts and assumptions characteristic of their depression and to consider evidence for more realistic views of their experience;
- Helping the person shift focus away from physical symptoms and negative mood associated with depression; and
- Helping the person return to a routine of pleasurable and productive activities, on a scheduled basis.

The treatment also typically involves psychoeducation about depression that normalizes the symptoms as part of an illness, which the person can do something about, rather than an indication of 'laziness' or 'a deficit in character'. In addition, it often involves learning techniques to solve problems and prevent relapse. Feelings of hopelessness are treated early on in treatment because they are associated with suicidality[3] and individuals do better in CBT when hopelessness is addressed effectively.[4, 5]

CBT for depression has been successfully administered in individual, group and couples formats. Individuals who have a more chronic or recurring illness may often require repeated interventions, or a shift in focus, to address early life experiences as well as personality, interpersonal, and identity issues.

Approximate Lifetime Prevalence: 7%

Diagnostic Criteria for a Depressive Episode:

For more than two weeks, five or more of the following symptoms are present (either depressed mood or decreased interest or pleasure must be one of the five).

1. For most of nearly every day, interest or pleasure is markedly decreased in nearly all activities
2. There is a marked loss or gain of weight or appetite is markedly decreased or increased nearly every day.
3. Nearly every day the patient sleeps excessively or not enough.
4. Nearly every day others can see that the patient's activity is agitated or compromised.
5. Nearly every day there is fatigue or loss of energy.
6. Nearly every day the patient feels worthless or inappropriately guilty.
7. Nearly every day the patient is indecisive or has trouble thinking or concentrating.
8. The patient has had repeated thoughts about death, suicide, or has made a suicide attempt.

In recent years, researchers have examined CBT in order to understand how, and with what symptoms and disorders, it works most effectively. For example, currently there is research looking at how to reduce ruminative thinking using CBT. Rumination, a common symptom in depression and anxiety disorders, is the process of thinking over and over about one's problems and their causes and consequences.[1] In

addition, a CBT technique called "behavioural activation", a process that emphasizes the individual "do" things in a structured way, has been specifically investigated. Behavioural activation can help patients focus on commencing, or resuming, normal routines of behaviour.[6] Another recent innovation in the treatment of depression is "mindfulness-based cognitive therapy" which incorporates techniques from meditation, and is designed to help prevent relapses in people with recurrent depression.[7]

2.0 Effects on Symptoms in Different Patient Populations

There is accumulating evidence that CBT is effective for individuals with acute depression, chronic depression lasting two years or more, and for recurrent depression. CBT has been proven effective with children over ten years of age, adolescents, and older adults. Furthermore, CBT may prevent the development of depression in children and adolescents.[8, 9] There is emerging evidence that CBT is effective in treating depressive symptoms in individuals with medical conditions such as rheumatoid arthritis, cancer, multiple sclerosis and brain injury.

3.0 Effects on Relapse Rates

During active treatment, the effects of CBT appear to be as effective as medication. However, several studies have shown that after treatment, relapse rates remain low for at least two years for people who have engaged in CBT (either on its own or after treatment with medication) as compared to those who have received medication alone. Interestingly, in one study that followed people for six years, individuals who received CBT had only a single relapse whereas those who received medication and were monitored by a psychiatrist had multiple relapses.[10] CBT that continues with monthly follow-up sessions can help to further reduce relapse rates[11], particularly in people whose depression had an early onset, or whose depressive symptoms did not disappear by the end of active treatment.[12, 13]

4.0 Effects on Global Measures of Functioning

In addition to reducing symptoms, CBT for depression also appears to have an effect on broader aspects of functioning that are generally maintained when people are followed after treatment. Generally, functioning in a person's work, school, home and leisure activities improves in concert with reduction in depressive symptoms both during and following a course of CBT.

5.0 Combined CBT and Pharmacological Treatment

In practice, CBT is often used as an adjunct to medication. Studies have compared the effects of a combination of CBT and medication in comparison to either CBT or medication alone. Some, but not all, studies show the combination of CBT and medication works better only in the case of severe or chronic depression but that CBT alone works as well as the combined treatment for mild-to-moderate depression. The combined treatment may also be of greater benefit in treating depressed adolescents.[14, 15] It is thought that CBT and medication act differently on different subgroups of depressed individuals, although this proposal requires further testing.

6.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

There is evidence that CBT works better than other psychological treatments that are also used to treat depression.[16] However, the effectiveness of other psychological treatments has not been studied as extensively as has CBT. It is the strong evidence base for CBT that makes it a compelling treatment approach when provided by qualified CBT practitioners. It is also possible that several psychological treatments, including CBT, have specific and common active ingredients that help reduce symptoms, for example, a strong therapeutic relationship.

7.0 Brief Therapy and 'Rapid Responders'

Most studies have evaluated CBT for depression using between 12 and 20 treatment sessions. However, a considerable proportion of people respond to CBT within the first few sessions of therapy.[17, 18] People who respond rapidly to CBT (or "rapid responders") tend to accept the cognitive model of their depression early on[17] and show an early increase in hope for the future.[5] Because of the rapid change some people experience in CBT, and because shorter treatments are less expensive and allow for more people to be seen more quickly, brief forms of CBT have been evaluated. There is some evidence that 6 to 8 sessions can be effective.[19, 20, 21, 22] Although no studies appear to have directly compared brief and standard CBT for depression, it appears that longer courses of CBT are more beneficial to individuals with severe depression.[23] In addition, it appears that whereas brief CBT works for rapid responders, those whose symptoms persist even after a standard-length course of CBT has been tried, will benefit from longer courses of CBT.[12]

8.0 Self-Help and CBT

Depression is common and can improve with CBT, however most cases go untreated. CBT for depression has been successfully adapted and validated within a self-help format using a book, computer program, or the internet. Qualified CBT practitioners could help many more individuals by delegating some of the more straight-forward aspects of treatment and after session practice to effective computer guidance.[24] Only some individuals (usually those with milder severity of depression) would be suitable for self-directed CBT; qualified CBT practitioners should screen and assess whether self-help CBT would be suitable and for any given individual.

9.0 What Predicts a Better Response to CBT for Depression?

Studies have shown that there are several factors that predict what kinds of people will benefit from CBT. Most of these factors are associated with less severe illness. For example, individuals with less severe illness, shorter length of illness, later age of illness onset, and fewer previous episodes of illness tend to respond well to CBT. Among adult populations, demographic factors such as gender, age and education generally do not affect outcome for CBT, although married people have been shown generally to do better than unmarried people. There is evidence that children respond better to CBT for depression than adolescents.[25]

While it was once thought that people with longstanding interpersonal and personality problems, in addition to their depression, respond poorly to CBT, there are now indications that these individuals benefit to the same extent as those without associated problems. It appears that people with longstanding interpersonal and personality problems, in addition to their depression, may be less likely to be symptom-free at the end of a fixed number of CBT sessions because they had more symptoms initially. Also, there is evidence that it is the beliefs associated with some personality problems (for example, paranoid thinking), rather than the depression itself, that can interfere with treatment.[26] As is the case with other psychological treatments, a good alliance between the practitioner and the person seeking treatment makes for a better outcome. It is possible, however, that rapid response to therapy contributes to a better alliance rather than the other way around.[27] In addition, a good alliance seems related to how well a person gets along with others in general and that people who have better interpersonal relationships do better in therapy.[28] Addressing painful feelings or managing suicide ideation can make it difficult ot engage in, or immediately benefit from CBT. However, it has been shown that approaching these feelings in a collaborative and exploratory way is linked to a better outcome of CBT.[29]

10.0 Role of the Family

Family participation in the treatment for someone with depression is important for a number of reasons. Often, a family history of depression exists. Also, family interactions may be strained or difficult if one family member is experiencing depression. It also may be important in the long-term for family members to recognize signs of relapse, so that timely treatment may be sought.[30]

11.0 Summary

- CBT has been widely validated by carefully designed research.
- CBT has been a widely used and successful intervention for depression.
- CBT requires specialized training to deliver.
- CBT helps prevent relapse and can be delivered in a range of formats to a wide variety of populations.
- CBT's effects on the symptoms of depression are comparable to the effects of medication in the short-term.
- At follow-up, CBT is superior to medication.
- More research needs to be done to establish whether CBT is superior to other available, but less researched, forms of psychological treatment, such as IPT.
- There is evidence that combining CBT with medication may enhance treatment effects for severe or chronic cases of depression.

CHAPTER 3 Depression

Jane saw a qualified CBT practitioner for 16 sessions. The practitioner assessed her symptoms, such as tiredness and poor concentration, and explained to her that these were the symptoms of depression that would return to normal once she had recovered. She found this information a great relief. The practitioner and Jane agreed that her therapy would focus on developing a routine of daily activities that they hoped would alleviate her depression over time. Jane kept a daily diary of her activities and their effects on her mood. She soon discovered that keeping a routine of activities improved her mood and increased her confidence. She and her practitioner discussed situations that had worsened her mood. For example, she had met a previous work colleague in the street who seemed to recognize her but did not go over and talk to her. When talking about these situations, the practitioner discovered that Jane was generating very negative, personalized meanings from these situations (for example, "She thinks that I am inferior") and then dwelling on them for long periods. The practitioner helped Jane to consider alternative explanations that were less self-blaming (for example, "She felt awkward"). By the end of therapy, Jane's symptoms were reduced to the extent that she was seeing her friends again and was considering returning to work part-time.

Elaine experienced her first episode of mania several months after giving birth to twins.

She stayed up all night to look after them and refused help from family members. She gradually needed less and less sleep each night, and became increasingly irritable with people around her. She spoke increasingly fast and her racing thoughts made it difficult to communicate with others. Elaine also went on spending sprees, routinely blowing the family's monthly budget. She was admitted to hospital where she eventually recovered from her mania but sunk into a deep depression. She gradually recovered from her depression with appropriate medication, but continues to experience mood swings, poor sleep and irritability towards her family. She wants to understand more about her illness and to prevent future relapse.

1.0 The Content of the Therapy

The use of Cognitive-Behavioural Therapy (CBT) for bipolar disorder began only a decade ago in the late 1990s.[1] People with bipolar disorder are at high risk of relapse. While depressive episodes are treated with CBT in much the same way as with depression, CBT for bipolar disorder has some distinct features:

- CBT for bipolar disorder is nearly always delivered in addition to medication, as it often stabilizes mood swings.
- CBT involves psychoeducation about the nature of bipolar disorder. Individuals come to understand that they have a biological vulnerability to episodes of mania and depression. These episodes can be triggered by stressors that the individual can learn to identify and cope with, thereby reducing the number of clinical episodes of either mania or depression.

Approximate Lifetime Prevalence: 1%

Diagnostic Criteria for Bipolar Disorder:

One or more lifetime episode of both depression and mania (Bipolar I) or hypomania (Bipolar II)

Mania requires a period of elated, expansive or irritable mood that lasts over a week. The person has persistently had three or more of these symptoms:

- Grandiosity or exaggerated self-esteem
- Reduced need for sleep
- Increased talkativeness
- Flight of ideas or racing thoughts
- Easy distractibility
- Psychomotor agitation or increased goal-directed activity (social, sexual, work or school)
- Poor judgment (as shown by spending sprees, sexual adventures, foolish investments)

Symptom severity results in at least one of:

- distress
- psychotic features
- hospitalization to protect the person or others
- impairment in work, social or personal functioning.

The symptoms for hypomania are the same, but they need only to be present for four days, and they do not reach the symptom severity criteria for mania.

- The individual is helped to understand his or her distorted negative and positive thinking. An example of distorted positive thinking might occur within a manic episode in which an individual believes he or she has terrific value and power and is capable of tremendous things. This form of delusional thinking might lead an individual to make decisions, like spending exorbitant amounts of money, that have profound negative consequences for them and others.
- CBT helps people with bipolar disorder manage regular daily routines. Otherwise, people with disrupted routines and poor sleep are at increased risk for developing mania.
- Relapse prevention is a critical feature of the treatment. People can be between manic episodes or depressed when they seek treatment. When manic episodes occur, they often have very negative consequences. The individual and practitioner work together to recognize warning signs and to develop coping strategies.
- It is difficult to engage people in CBT when they are experiencing manic symptoms or if they are suicidal, especially early on in their illness. They may not accept that they are ill and in need of treatment. On the other hand, individuals with a long history of illness may have developed co-occurring disorders (for example, substance abuse) and a degree of neuropsychological impairment that may need to be considered and treated concurrently.[2]

2.0 Effects of CBT

To date, only one well-designed study of CBT for individuals with bipolar disorders has been published.[3] Participants received between 12 and 20 sessions of CBT, the results of which were compared with a traditional course of medication. Over the 6 months following treatment, the CBT group had fewer episodes of either mania or depression as well as fewer hospital admissions related to their illness. At 6 months post-treatment, the CBT group also had higher social functioning and lower levels of depression.

Preliminary results indicate that CBT is effective for individuals who have experienced fewer than 6 episodes of either mania or depression.[4] Pilot studies of CBT have shown a reduction in bipolar symptoms.[5,6] Further, treatments that employ components of CBT, such as group psychoeducation and relapse prevention, have been successful in reducing the risk of relapse.[7, 8]

3.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

No studies have directly compared CBT for bipolar disorder with another psychological intervention. However, there is good reason to expect that at least two alternative theory-based treatments are also effective Family-Focused Treatment (FFT)[9] and Interpersonal and Social Rhythm Therapy (IPSRT)[10]. Notably, they are similar to CBT in that they are time-limited interventions that combine psychoeducation about the illness with teaching the person mood management and relapse prevention skills within the context of a therapeutic relationship.

4.0 What Predicts a Better Response to CBT for Bipolar Disorder?

Initial findings show that individuals with a history of fewer than six episodes of mania or depression and fewer co-occurring disorders benefited from CBT.[4] Lam and colleagues (2003) found that people who reported a realistic sense of themselves and their limitations benefited most from CBT.[3] In contrast, individuals who described themselves and their 'ideal self' as having traits such as high intelligence and extreme levels of energy and creativity, did not benefit from CBT. Therefore, as seen with other disorders, illness severity is predictive of an individual's response to treatment. It should be noted that some individuals with bipolar disorder value their manic episodes, as they often feel more creative and productive during these times. These beliefs, when exaggerated or unrealistic, would likely be challenged in the course of CBT treatment, especially in an attempt to avoid the devastation of the depressive episodes.

5.0 Role of the Family

Bipolar disorder can have a devastating impact on the families of individuals that suffer from it. Screening for manic episodes and interviewing and involving family members or significant others are important in identifying and treating bipolar disorder. If families can identify early warning signs of an impending manic or depressive episode, they can be better equipped to circumvent, or be sure that the individual adheres to their treatment plan, taking of medication, etc.

The Family-Focussed Treatment (FFT) model developed by Goldstein and Miklowitz (1997) is the most widely researched family intervention.[11] The goal of treatment is to involve close family members in treatment to improve family and individual functioning. This is achieved using a combination of communication, problem-solving and coping strategies training, psychoeducation and relapse rehearsal. One study had random assignment of individuals to FFT and comparison treatments. The FFT group received 21 sessions of FFT compared with standard care and a brief two session family intervention. Individuals receiving FFT showed a greater improvement than the standard care group in

depressive symptoms, but no differences were observed in manic symptoms. At 2-year follow-up, the FFT group experienced fewer relapses than individuals in the standard care group (71% versus 47%).

Similar results were achieved by other researchers who randomly allocated 53 individuals with a recent admission to hospital for mania to 21 sessions of FFT or 21 sessions of individual support and problem-solving treatment.[12] The active treatment phase was 9 months and individuals were followed up for a further 15 months post-therapy. Those receiving FFT were significantly less likely to be re-hospitalized during the follow-up period and were less likely to experience a relapse during the second year post-treatment (28% for the FFT group versus 60% for the individual support group).

6.0 Summary

- CBT has only recently been applied to individuals with bipolar disorders.
- CBT requires specialized training to deliver.
- To date, CBT has been shown effective in certain subgroups of individuals at early stages of their bipolar illnesses.
- CBT for bipolar disorder is delivered as an adjunct to medication.
- Recent research suggests that, early in the course of bipolar disorder, CBT can be effective in reducing symptoms and relapse rates, and in improving social functioning.

CHAPTER 4 Bipolar Disorder

Elaine received 20 sessions of CBT for bipolar disorder. She began by producing a "life chart" which helped her understand how her illness developed, and that medication had been useful for reducing symptoms. She monitored her mood and activity using a daily schedule. This allowed her to pinpoint the triggers for her mood swings and helped her to plan her studies around looking after her children. When she felt energized and active, she would often perceive others as being deliberately malicious when they tried to calm her down. During therapy, she was encouraged to see her own behaviour from others' perspective, which helped her see their reactions less negatively. She worked with her practitioner to generate a list of early, middle and late warning signs for mania and depression, along with effective coping strategies for each stage of warning signal. She was able to return to her studies during the day while her children were at school.

Dan began drinking alcohol as a teenager, and smoked marijuana on a weekly basis during high school.

He tried cocaine while at university, but was regular in his use of alcohol. After beginning to practice law, Dan would often have drinks with lunch and during evening meetings. Dan is now 45 years old. Five years ago his physician cautioned Dan that he needed to lose weight and reduce his blood pressure. His wife had long been encouraging him to eat better and get regular exercise. Dan realized that he had gained weight, but did not make a connection between this and his use of alcohol. Recently, a senior partner at Dan's firm expressed concern, and advised Dan to "get a handle" on his drinking. Dan is not sure what to do. He does not believe that he is an "alcoholic". Under pressure, he made an appointment with a Psychologist and has assured his senior partner that things are under control. On the day of his first appointment he had "a couple" of drinks with lunch before meeting his Psychologist.

CHAPTER 5 Substance Use Disorders

As a class, substance use disorders (Substance Dependence and Substance Abuse) are the most common forms of mental disorders. They also account for the greatest burden of disease and mortality of all mental disorders. The use of psychoactive substances, including alcohol, tobacco and illicit drugs, contributed to 12.4% of deaths worldwide in the year 2000.[1] Alcohol alone is responsible for 4% of the global burden of disease, which is equal to the rates of death and disability due to tobacco and hypertension combined.[1, 2] Problems involving substance use include licit and illicit drugs, as well as the misuse of prescription medications. In addition, substance use problems often occur in association with depression, anxiety, and virtually all other forms of mental illness.

1.0 The Content of the Therapy

Cognitive-Behavioural Therapy (CBT) for substance use problems can include a number of different techniques and practices, and the particular elements of therapy will vary in response to individual needs. Nevertheless, the application of CBT in this area shares many of the principles outlined elsewhere in this volume: collaboration; individualized learning; structure and mutual accountability; and, understanding problems in the context of the individual's life and circumstances. The latter includes paying careful attention to the individual's level of readiness to change their substance use. Applied to substance use problems, treatment with CBT typically includes the following:

- Assessing and monitoring motivation for change;
- Development of a trusting and collaborative therapeutic alliance;
- Setting goals and evaluating progress through self-monitoring and reflection in therapy;
- Development of coping skills and alternatives to substance use;
- Identifying high-risk situations and learning to avoid or manage these differently;
- Identifying emotional and cognitive "cues" associated with risk for substance use; and
- A focus on preventing relapse and maintaining change through continuous learning.

Qualified CBT practitioners can select from a wide variety of techniques in order to address substance use problems faced by an individual. These include: anger management; aversion treatment; behavioural contracts; exposure and response prevention; mindfulness training; modelling; relapse prevention; relaxation training; social skills training; and stress management.[3]

Cognitive-behavioural practitioners focus on the role of learning and habit formation as contributors to the development of substance use problems. The same learning processes that lead to the development of problems can be harnessed to change behaviour and promote the development of new, less harmful habits.

Approximate Lifetime Prevalence: varies widely by substance

Diagnostic Criteria for Substance Dependence:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   (b) Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
   (a) The characteristic withdrawal syndrome for the substance.
   (b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is a persistent desire of unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Approximate Lifetime Prevalence: varies widely by substance

Diagnostic Criteria for Substance Abuse:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
2. Recurrent substance use in situations in which it is physically hazardous.
3. Recurrent substance-related legal problems.
4. Continued substance use despite having persistent or recurrent social of interpersonal problems caused or exacerbated by the effects of the substance.

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

The first order of business in treating substance use is the management of detoxification, if necessary. CBT practitioners tend to adopt a "harm reduction" perspective, in which abstinence represents the lowest level of harm, but allowing for mild to moderate substance use (either short or long-term). The ultimate selection of treatment goals will be influenced by the individual's abilities – if moderation is not sustainable, then abstinence may be necessary. For some individuals, moderation may serve as a step leading to abstinence. The individual's motivation for change is a key factor influencing treatment, and should be monitored and supported throughout a course of CBT.

Change in CBT is based on a thorough functional analysis of behaviour, focusing on the factors that precede, "trigger," and maintain substance use. The functional analysis will highlight the role of the physical environment as well as the skills (and skills deficits) of the individual. The combination of internal and external factors often exposes "high-risk" situations (for example, leaving work, tired and frustrated). Based on this analysis, CBT proceeds to introduce individualized skills and sensitizes the individual to apply these skills in certain contexts. The

individual keeps track of his or her success with different strategies and modifies them accordingly. The final stage of treatment involves relapse prevention. Here the individual must identify potential high-risk situations in advance and be satisfied that they are capable of managing these situations without suffering a setback in their substance use. The process of anticipating and managing "risky" situations can itself become a habit.

2.0 Effects on Symptoms in Different Populations

CBT has been shown to be effective in relation to a range of specific substances, including nicotine, alcohol, marijuana, cocaine, and opiates.[4, 5, 6] In addition, CBT has been shown to be an effective means of reducing harmful substance use among people who have co-occurring mental health problems. Depression is one of the most common disorders to co-occur with alcohol dependence, and CBT has been found effective in the management of these co-occurring problems.[7, 8] Other studies have reported positive substance-related outcomes with individuals who have schizophrenia[9,10], bipolar disorder[11], social phobia[12], posttraumatic stress disorder[13], and personality disorders.[14] Cessation of drinking often leads to side effects, such as sleep disturbance, and here again CBT has delivered significant improvement.[15] While the bulk of research has been conducted on young to middle-aged adults, CBT also shows promise with adolescent substance users,[16, 17] as well as with older individuals.[18]

3.0 Effects on Relapse Rates

Considerable evidence supports the effectiveness of CBT in preventing relapse to harmful levels of substance use. The concept of relapse prevention was popularized and has been significantly developed within the field of substance use treatment.[19,20] Some of the principles of relapse prevention have become part of the typical course of CBT for substance use (for example, identification and management of high-risk situations). Relapse prevention materials have been developed in workbook format, and for use with groups, couples, and families.[21, 22] In addition, relapse prevention has been effectively incorporated with pharmacological treatments for substance use problems.[23]

4.0 Combined CBT and Pharmacological Treatment

The effectiveness of treatment is sometimes enhanced through the concurrent implementation of pharmacotherapy with CBT. For example, the combination of medication with CBT has produced significantly better outcomes for alcohol dependent individuals than the results of CBT alone.[24, 25, 26] Other research has shown that pharmacotherapy enhances abstinence outcomes when used alongside CBT with alcohol dependent individuals.[27] The optimal integration of CBT with medication to treat substance use is an emerging area of science. In the treatment of cocaine, for instance, both CBT and medication are efficacious, but their combination may not surpass their effectiveness individually.[28]

5.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

Numerous studies have compared CBT with non-specific interventions, medication, and other psychological treatments. In general, these comparisons have favoured the effectiveness of CBT. In some cases the effectiveness of CBT has not been evident during active treatment, but becomes apparent at follow-up intervals.[29, 30] This observation suggests that gains made through CBT may take some time to incorporate in everyday behaviour. Among alcohol-dependent outpatients, CBT has been shown to be equally effective to Motivational Enhancement and Twelve-Step Facilitation (TSF). However, individuals expressed higher levels of satisfaction with CBT versus the other two therapies.[31]

6.0 Brief Interventions, Brief Therapy and CBT

Brief interventions can play an important role prior to CBT. They are designed to enhance motivation for change, and are successful when they lead an individual to begin making changes, either on their own or with professional support.[32] Separate from *brief interventions*, CBT is identified as a *brief therapy* for substance use, usually spanning between 10 and 20 sessions. The appropriate number of sessions will vary for each individual, and it is not possible at this time to declare a particular number of sessions as having the best dose-response effect for individuals in general.

7.0 Self-Help and CBT

CBT has been adapted for use in self-care[33] and early intervention settings.[3] In addition, CBT has been used in group formats, including groups that address co-occurring psychological problems.[34]

In CBT, substance abuse is a learned behaviour that can be modified through self-control strategies, that is, what individuals can do to recognize the processes and habits that underlie and maintain substance use and what can be done to change them.[35] The qualified CBT practitioner may explore with the individual the ways in which going to a Twelve-Step Facilitation meeting when faced with strong urges to use may be a very useful and important strategy to cope with craving. However, qualified CBT practitioners will also encourage individuals to think about and have prepared a range of other strategies as well. An example of a self-help manual for treating cocaine addiction appears online at http://www.nida.nlh.gov/txmanual/CBT/CBT3.html.

8.0 Concurrent Disorders and CBT

In community studies of mood disorder and substance abuse, lifetime prevalence of depression among substance users is much higher (24.3%) than the rate in the general population (5.8%).[36, 37] Furthermore, rates of substance abuse disorders among those with depression (27.2%) and bipolar disorder (60.7%) are also very high.[36] As well, phobic anxiety disorders, and in particular panic disorders, appear to be most highly associated with alcohol use disorders. Symptoms of anxiety and depression may not only interfere with optimum outcomes from substance abuse treatment, but are frequently reported as triggers for relapse.[19, 38-42]

The best current evidence for the treatment of substance use disorders concurrent with mood and anxiety disorders is CBT.[36] The *Best Practices Guide for Concurrent Mental Health and Substance Use Disorders* (2002) recommends an integrated approach to treatment and support. As well, a sequential approach to treatment (for example, treating the substance use disorder first) is generally recommended, with the exception of post-traumatic stress disorders (PTSD) where simultaneous treatment is preferred.[36,43] Results show that people who were recovering from an alcohol use disorder were 16.7 times more likely to recover from their mood/anxiety disorder than people who did not recover from their alcohol use disorder.[36]

9.0 What Predicts A Better Response To CBT with Substance Use Disorders?

Considerable efforts have been made to identify the optimal circumstances to use CBT or other treatments for substance use problems, such as Alcoholics Anonymous or Motivational Enhancement Therapy.[44] Despite these efforts, relatively little is known regarding the characteristics of individuals that would suggest a better (or worse) "fit" with CBT. Stated more positively, a wide variety of individuals and presenting problems can be treated effectively using CBT. Some patterns of substance use have a negative impact on cognitive impairment, and researchers have begun examining whether cognitive functioning is related to the effectiveness of CBT. For example, among people seeking treatment for cocaine dependence, those who completed treatment had significantly better cognitive performance at the beginning of treatment than those who dropped out.[45]

Individuals who are not currently contemplating change (or are resistant to the idea) may benefit initially from an approach that focuses on motivation. In practice, motivational enhancement techniques are often integrated into the administration of CBT. People who change their substance use frequently encounter challenges to their resolve, and must be supported through these periods.

Although relatively little is known about the process of matching treatments (including CBT) to individuals, skilled practitioners are able to adapt CBT to a wide variety of people and circumstances.

10.0 Role of the Family

Among adolescents the evidence suggests that CBT may be slightly more effective than other psychological treatments for some groups, and the combination of family therapy with CBT has greater impact than CBT alone.[46, 47, 48] Family therapy may be especially important for youths that are using substances and have associated mental health problems, or are considering suicide.[49]

11.0 Summary

- CBT for substance use disorders is a collaborative, person-centred approach that systematically empowers people to change their behaviour.
- CBT is among the most widely studied and effective treatments for substance use disorders.
- Evidence supports the effectiveness of CBT in the treatment of problems involving a variety of substances as well as with individuals who have substance use and other co-occurring mental disorders.
- CBT helps prevent relapse and can be delivered in a range of formats to a wide variety of populations.
- CBT can be effective when accompanied by pharmacotherapy (use of medications) for certain disorders, and in other cases it is the current treatment of choice.

Dan's first appointment with his Psychologist ended abruptly. Having established that Dan had been drinking before the appointment, the Psychologist politely but firmly advised that Dan should reschedule for a later time when he was prepared to come sober. Initially Dan was mad, but he felt that he had no choice. When he returned, the Psychologist encouraged Dan to look at the pros and cons of drinking, and the pros and cons of changing his alcohol use. Dan was surprised to see a number of "pros" associated with change (financial savings, weight loss, less tension at work), and agreed to focus on one or two of these to begin with. He selected the goal of moderate drinking rather than abstinence, and his Psychologist agreed to pursue that goal, but cautioned Dan that he may need to consider abstinence if moderation was not achievable. Dan was required to maintain a log in which he monitored his drinking, including how much he drank, how he felt, who he was with and where he was. Dan learned that there were certain situations in which he felt an urge to drink, particularly when he felt stressed or angry. He recognized that alcohol was not the best way to deal with these situations, and he began working with his Psychologist to develop alternative ways of coping, including regular exercise. Dan began monitoring his weight, which slowly declined. Dan experienced lapses in his alcohol use, which his Psychologist encouraged him to learn from, rather than allowing them to become "relapses" (that is, returning to his old patterns). Over time, Dan experienced a number of clear benefits to change, including improved relationships, weight loss and financial savings. He recognized that he would need support to maintain the changes in his drinking, including from his wife, his psychologist and his family doctor. Dan accepted that his drinking had developed over many years, and that changes would likely also take time.

CHAPTER 6 Generalized Anxiety Disorder (GAD)

Joshua was a high functioning physician who left his wife one year ago for a new partner.

While planning the separation, he worried excessively about a range of matters including the potential financial settlement, access to his children and where he would live. His worries worsened after he left his wife, and his new partner was finding it difficult to cope with his constant worrying. He felt unable to work, as he feared making a mistake due to his physical exhaustion and inability to concentrate. He spent his time contemplating all possible endings to what he described as a 'nightmare' situation. He suffered from frequent headaches, which he attributed to being unable to 'switch off' his mind. He recognized that his worries were excessive.

1.0 The Content of the Therapy

The work of Dugas and colleagues (2003) illustrates the current approach to Cognitive-Behavioural Therapy (CBT) treatment for Generalized Anxiety Disorder (GAD).[1] This approach includes:

- Worry Awareness Training – this is a necessary first step since most people with GAD are either unaware of their worry patterns or they incorrectly consider them to be helpful;
- Coping with Uncertainty – those with GAD fear uncertainty and work to ensure predictability (that is, usually whatever worked before) and so are purposely exposed to increasingly uncertain situations relevant to their worry themes. Trusted others (for example, partners, parents) are instructed not to provide reassurance when the person with GAD requests it, instead are asked to answer with, "I don't know", "I guess you'll see", etc.;

Approximate Lifetime Prevalence: 5%

Diagnostic Criteria for Generalized Anxiety Disorder:

Excessive anxiety and worry (apprehensive expectation) about multiple events/activities.

1. Worry occurs for more days than not over the past 6 months.
2. The worry is hard to control.
3. The anxiety is associated with 3 (or more) of:
   a. Restlessness/being keyed up or on edge
   b. Being easily tired
   c. Difficulty concentrating or mind going blank
   d. Irritability
   e. Muscle tension
   f. Sleep disturbance.
4. The content of the worry and anxiety is not confined to the features of an Axis I disorder for example, being contaminated (as in Obsessive-Compulsive Disorder).
5. The anxiety, worry or physical symptoms cause clinically significant distress or impairment in functioning.

The disturbance is not due to the physiological effects of a substance or general medical condition and does not occur exclusively during the course of a mood disorder, psychotic disorder or pervasive developmental disorder.

- Re-evaluating Beliefs About Worry – people with GAD believe worry is useful and that it is helpful in preventing bad outcomes. Beliefs about the value of worry are challenged and tested;
- Problem-Solving Training – problem-solving is presented as an efficient alternative to worry. People are taught to shift from endless worry, into a problem-solving process; and
- Cognitive Exposure – those with GAD routinely engage in cognitive avoidance of troubling thoughts (they simply get rid of them immediately!) with the result that the associated anxiety remains. Cognitive exposure requires individuals to systematically contemplate their feared thoughts and images until their anxiety drops by about 50% (usually within 20 minutes).[1]

Another approach, developed by Tom Borkovec and his colleagues (2002), focuses more on self-control and relaxation.[2]

Specifically, the treatment involves having the person (a) monitor his or her anxiety; (b) learn and use a range of relaxation strategies; (c) learn and practice new coping strategies within sessions; and (d) learn and use a range of cognitive strategies so that thoughts and perceptions are more accurate and adaptive.

The U.K. National Institute of Clinical Excellence (NICE) has recently issued evidence-based guidelines for the treatment of GAD; http://www.nice.org.uk/pdf/CG022NICEguideline.pdf.[3] Specifically, there is evidence for the following recommendations:

- CBT should be delivered only by suitably trained, supervised and qualified mental health practitioners who follow research-based treatment protocols;
- Research shows the optimal range of CBT duration is 16-20 hours;
- Some research shows that less contact (8-10 hours) is also effective; and
- CBT should take the form of weekly sessions of 1-2 hours and should be completed within a maximum of 4 months of commencement.

2.0 Effects on Symptoms in Different Populations

There is strong research support for the use of CBT for Generalized Anxiety Disorder, such that CBT is the psychological treatment of choice for this disorder.[3] The lowest symptom severity and least amount of future treatment required have been shown by individuals in programs of CBT and applied relaxation.[4] Some individuals reported treatment gains at follow-up periods ranging from 6-12 months. There is some indication that people can maintain their treatment gains for even longer follow-up periods of 8 to 14 years.[4]

CBT treatment has also been found effective with older adults and youth.[5,6] However, many studies of children do not distinguish among different anxiety disorders, therefore, few studies specifically address the usefulness of CBT for children with GAD. Nevertheless, there is some indication that CBT is likely to be helpful for children and adolescents. When assessing GAD in children, differences between parent and child report of physical symptoms, as well as the child's age and developmental level should be considered.[6]

3.0 Group Treatments

Group CBT is an effective treatment for GAD, with individuals showing improvement on all symptoms of GAD maintained at 2-year follow-up.[1] In large group settings, cognitive therapy, behaviour therapy and cognitive-behaviour therapy have been found to be more effective than putting someone in a group which receives periodic attention but no active therapy, both in the short and long term. Group CBT has been shown to be specifically effective for children with anxiety disorders, including GAD.[7]

4.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

Individual CBT appears more effective than no intervention, medication, psychodynamic psychotherapy or non-specific psychological interventions.[4] CBT was associated with the lowest dropout rates and largest improvements when tested against other psychological therapies for GAD.[8] Specific CBT techniques such as anxiety management training, relaxation and breathing-for-relaxation therapies have been found to be more effective than no intervention.[2]

5.0 Comparison with Pharmacological Interventions

Cognitive and behavioural techniques have been shown to be as effective as medication in the short term. More studies are needed to demonstrate the relative effectiveness of each in the long term. A meta-analysis of 35 studies examining cognitive-behavioural therapy and medication for GAD[9] reported no statistically significant differences in drop-out rates or in reduction of GAD symptoms between the two interventions. However, CBT demonstrated a greater positive impact on depressive symptoms that were associated with the GAD with gains maintained over time, whereas drug therapies were of less benefit over time.

6.0 Self-Help and CBT

Self-help approaches have an important role to play in the treatment of GAD, particularly in combination with pharmacological or psychological interventions provided by a qualified CBT practitioner.[3] Computer-aided delivery of CBT is seen to have potential within a combined protocol although in some individuals, self-help approaches may be successful interventions on their own. One study found that participants with GAD had maintained treatment gains from a self-help intervention to control worry at a 2 year follow-up.[10]

7.0 What Predicts a Better Response to CBT?

Findings from Gould's (1997) meta-analysis showed that treatment outcome was unrelated to the severity or duration of GAD symptoms.[9] However, other researchers have suggested that marital status, marital tension and the complexity of other co-occurring disorders can impact on the success of treatment.[11] Average drop-out rates for CBT for GAD are only 10%.[9]

8.0 Role of the Family

Family participation in an individual's CBT treatment could be done in an effort to educate family members on the risks of relapse. Family members can be instructed not to provide reassurance when the person with GAD requests it, helping the individual to learn to cope with uncertainty.[1] As well, interpersonal family functioning can be improved and thus, decreasing an individual's stress to inoculate against risk of relapse.

9.0 Summary

- Individualized CBT for GAD is an effective treatment.
- CBT is as effective as medication for GAD.
- CBT requires specialized training to deliver.
- CBT helps to produce lower symptom severity and less future treatment when compared to other psychological treatments for GAD.
- Treatment has been found to be effective for older adults and youth, and when administered in a group format.
- Adaptations of the treatment to everyday clinical settings and alternative forms of delivery, such as self-help when indicated, appear promising.

CHAPTER 6 Generalized Anxiety Disorder (GAD)

Joshua had 16 sessions of CBT for generalized anxiety disorder. It soon emerged that Joshua believed strongly that it was his responsibility to 'think things through' and that it was only by thinking through all possible scenarios that he would be prepared for any eventuality. He believed that since he had caused the problem, he should be able to solve it on his own. Treatment consisted of a thorough assessment of his beliefs about the positive functions of worry. These beliefs were challenged in multiple ways, including collecting information about how other people in similar situations have addressed their concerns, behavioural experiments to see if worrying really was helpful in any way, and cognitive restructuring. An important component of treatment was problem-solving to help Joshua put his thoughts down on paper, be as 'thorough' as he felt was necessary but help him to actually implement a solution and see its effects. Joshua found it hard to tolerate the uncertainty that was pervasive in his situation, and methods to help him manage this were implemented. By the end of treatment, Joshua was able to return to work and had agreed to some financial arrangements with his ex-wife. His new partner had left him during the course of treatment, which both created and alleviated some anxiety! He was, however, able to handle her departure without the excessive worrying that had been so disabling prior to treatment.

CHAPTER 7 Panic Disorder

Ella was an 18 year-old woman who had been suffering from panic attacks for the last year.

These attacks began immediately after she smoked some marijuana one night, and she became concerned that her parents would find out. Her first panic attack occurred in a large department store. Since that time she has avoided shopping there. She has avoided a lot of situations where she could have a panic attack, including the cinema, supermarkets, and concerts. During her first few panic attacks, she thought that she was having a nervous breakdown. One time her heart was beating so fast she feared it might jump out of her chest. She visited a hospital emergency room because she was afraid that she was having a heart attack or a nervous breakdown. The doctors there recognized the symptoms of panic and helped her find a mental health practitioner for treatment.

1.0 The Content of the Therapy

Cognitive-Behavioural Therapy (CBT) for panic disorder has evolved quickly over the recent past. For example panic control treatment (PCT) was developed by David Barlow and Michelle Craske (1994).[1] The goal of PCT is to help the individual identify and correct the maladaptive ways of thinking and behaving that maintain the panic disorder. PCT combines education, cognitive interventions, relaxation and controlled breathing exercises, and exposure techniques.

Exposure techniques for panic involve making the person experience symptoms of panic, initially in a safe environment (for example, the practitioner's office). For example, spinning the person might bring on dizziness, breathing through a straw might bring on sensations of smothering, and vigorous exercise may be used to generate a racing heartbeat. By provoking and experiencing the symptoms of panic, sufferers may learn not to fear them.[2] PCT is typically delivered in 11 or 12 weekly sessions and there is good evidence that it works.[3]

David M. Clark and his colleagues in the UK recognized that people misinterpreted physical symptoms of anxious arousal and therefore placed more emphasis on correcting cognitive misinterpretations of these symptoms.[4] For example, an increase in heartbeat is thought to be the beginning of a heart attack. Treatment involves helping people to re-evaluate their bodily sensations. Particular attention is paid to the "safety behaviour" or what the person does in an effort to reduce anxiety and avert disaster. In the previous example, when experiencing an increase in heart rate, the person's safety behaviour might be lying down or going to an emergency room. Although the safety behaviour is intended to reduce anxiety, it actually reinforces misinterpretation of symptoms (for example, "my increased heart rate means I am having a heart attack") and maintains anxiety (for example, "I might die from this heart attack"). As a result, the person does not allow himself the opportunity of carrying on with what he had been doing.

Clark's CBT treatment for panic originally involved 12 to 15 one hour sessions. A briefer version, requiring a total of 6.5 hours of therapy has been developed.[5] Cognitive therapy and treatments based on deliberate exposure to the symptoms of panic (that is, provoking sensations of dizziness, racing heart, etc.) are effective in the treatment of panic. The use of relaxation strategies alone may be insufficient to treat persistent panic attacks.[6]

The National Institute of Clinical Excellence (NICE) in the UK[7] has recently issued evidence-based guidelines for the treatment of Panic Disorder, http://www.nice.org.uk/pdf/CG022NICEguideline.pdf. Specifically, there is evidence for the following recommendations:

- CBT should be used for Panic Disorder and only by suitably trained and regulated health care professionals who follow research-based treatment protocols;
- The optimal number of CBT treatment hours, 7 to 14, should be offered;
- For most people, CBT should be delivered weekly, 1 to 2 hours per treatment, and completed within 4 months of commencement; and
- Briefer CBT should be supplemented where appropriate with focused information and tasks.

Approximate Lifetime Prevalence: 1.5% - 3.5%

Diagnostic Criteria for Panic Disorder without Agoraphobia:

Recurrent and expected Panic Attacks, that is, a discrete period of intense fear or discomfort in which 4 or more of the following develop abruptly and peak within 10 minutes:

1. Palpitations, heart racing/pounding
2. Sweating
3. Trembling
4. Shaking
5. Shortness of breath
6. Feeling of shocking
7. Chest pain or discomfort
8. Nausea or abdominal distress
9. Derealization or depersonalization
10. Fear of losing control or going crazy
11. Fear of dying
12. Numbness or tingling
13. Chills or hot flushes.

The attacks have been followed by:

- Persistent worry about having another attack
- Worry about implications of the panic attack
- A change in behaviour related to the attacks.

The panic attacks are not due to the direct physiological effects of a substance or better accounted for by another disorder.

Panic disorder with agoraphobia occurs when patients are anxious about being in places or situations from which escape may be difficult or embarrassing, or for which help may not be available, for example, being in a crowd. The situations are avoided or else endured with distressor only in the presence of a companion.

Patients can be diagnosed with Panic Disorder without Agoraphobia, Panic Disorder with Agoraphobia, or Agoraphobia without a history of panic disorder.

2.0 Effects on Symptoms in Different Populations

There is some indication that CBT works with older adults[8] as well as children.[9] It is worth noting that panic attacks in children may be different from those seen in adolescents and adults. More specifically, unlike in adolescence and adulthood, most panic attacks in childhood appear to be associated with particular events and are not unexpected or "out of the blue".[9]

3.0 Group Treatments

Panic disorder treatment via CBT is frequently delivered in a group format, and has been found to be an effective option.[10] In a well-designed study comparing group and individual formats, people who received either group or individual treatment did significantly better than those on a wait list for treatment.[11] People in group and individual treatments did equally well in symptom reduction. It is interesting to note that 95% of people who were on the wait list opted for individual rather than group treatment once treatment became available to them.

4.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

Most of the research into CBT for Panic Disorder has compared one CBT component with another (for example, psychoeducation, exposure, and thought reinterpretation). Although it has not been specifically compared with CBT, eye movement desensitization and reprocessing (EMDR) does not appear to be effective at reducing frequency of panic attacks or anxious cognitions.[12] The relative effectiveness of other therapies in comparison with CBT (such as hypnosis, interpersonal therapy, or psychoanalysis) for individuals with panic disorder has not been studied.

5.0 Comparison with Pharmacological Interventions

The United Kingdom National Institute for Clinical Excellence[7] (NICE) has concluded that psychological, pharmacological and combinations of these interventions are effective for panic disorder but it is not clear whether combination interventions are definitively better than CBT or pharmacological intervention alone. Nevertheless, people are more likely to comply with CBT than with medication treatment and individuals who have undergone CBT remain symptom free longer than those who have been treated with medications. Kampman and his colleagues (2002) have suggested that individuals who are not responsive to CBT for panic disorder become responsive if medication is added to the CBT treatment.[13] There are data that suggest people who have used medication for a long time do not respond as well to subsequent psychological therapies.[7]

6.0 Predictors of Outcome

At present, there is no definitive way for the qualified CBT practitioner to predict which intervention (pharmacological, psychological or self-help) will work best for which person. There is some indication that lower education and poorer motivation lead to a greater likelihood of dropping out of treatment.[14] Keijsers and colleagues (2001) also found that the more severe the panic disorder before CBT, the poorer the post-treatment outcome at 2 year follow-up.[15] Finally, those who complete any between-session practice assigned through the course of CBT treatment are more likely to do better than those who do not.[6]

7.0 Presentation at Emergency Departments

Some symptoms of panic attacks, such as heart palpitations, may lead some people to think they are experiencing a potentially life-threatening event, such as a heart attack. These misinterpretations of the symptoms of panic often lead individuals to present to Emergency Departments. It has been estimated that between 18% and 25% of people who present to emergency or outpatient cardiology settings meet the criteria for panic disorder.[7, 16]

8.0 Self-Help and CBT

It appears that CBT for panic disorder is equally effective when delivered in community mental health settings as when delivered for the purposes of research.[17, 18] Standard-length CBT (approximately 12-20 sessions) has been compared to brief CBT (approximately 1-6 sessions) and to self-help (or "bibliotherapy").[19] Although the standard therapy group showed the greatest improvement, all three groups showed improvement. CBT has been shown to be superior to a bibliotherapy group alone, but the latter is still considered to have utility, particularly in a primary care setting. Other forms of help (phone therapy, computer-assisted therapy) may be considered as part of the treatment plan.

Brief cognitive therapy may be as successful as standard-length therapy.[5] Approximately 50% of people are reported to respond well to a CBT intervention comprising self-help plus telephone contact.[20] A scale has been developed to help qualified CBT practitioners to choose among psychoeducation, self-help or face-to-face therapy as the first step in a stepped approach to treatment.[21]

9.0 Role of the Family

Family members can play an important role in a person's treatment by offering support. Learning to recognize the symptoms of panic, or understanding the family member's course of treatment, can help an individual to stay calm and focused (http://www.seekwellness.com/conditions/mental/panic_disorder.htm).[22]

10.0 Summary

- CBT yields large improvements with persons having panic disorders and treatment gains are well maintained.
- CBT requires specialized training to deliver.
- When it is administered alongside pharmacotherapy, CBT reduces the risk of relapse.
- There is no definitive way to predict to which treatment a person with a panic disorder would respond best.
- CBT treatment and self-help therapy can be used successfully in community health care settings.

Ella was offered 6 sessions of CBT with her mental health practitioner and was given 'workbooks' with exercises to help her learn about her panic attacks. Ella and her practitioner developed a personalized formulation regarding the maintenance of her problem and together discovered that the sensations of her head exploding could be induced in the therapy session simply by asking her to recall some past anxiety experiences. This helped Ella to accept emotionally that many of her symptoms were due to anxiety rather than an indication of an imminent breakdown. Psychoeducation regarding the impact of anxiety was an important component of treatment as she was able to recognize that anxiety cannot cause brain damage. She began to gradually revisit some of the places she had avoided, initially with a friend and later on her own. Her fear that she would have a panic attack began to subside and by the end of treatment she was no longer experiencing any panic attacks.

CHAPTER 8 Obsessive-Compulsive Disorder (OCD)

Mia, aged 35, remembers the time when she was 7 years old and reading in bed, when her mother told her an elderly neighbour had died.

From that time on, Mia never read in bed as she was afraid that her reading would cause someone to die. As an adult, she described being assailed by thoughts of her children dying. To help herself feel better, she repeated the phrase 'my children are okay' twelve times in her head. She repeatedly checked the locks and doors in her house to ensure that nobody could come in and harm the children. If she saw anything associated with death (for example, a hearse), she was afraid that it was an 'omen' and she immediately checked on her children to seek reassurance that they were well.

Over time, Mia began to worry that she may accidentally harm her children, for example by giving them chicken that had not been cooked properly. She avoided cooking raw meat as it caused her so much anxiety and she was constantly disinfecting all the kitchen surfaces and her hands. Mia's anxiety and compulsive behaviour made her think that she was going mad.

She knew that she didn't make any sense but she was too afraid to stop, thinking that if she did so then one of her children would die.

CHAPTER 8 Obsessive-Compulsive Disorder (OCD)

Obsessive-compulsive disorder (OCD) is a relatively common disorder with a lifetime prevalence of approximately 2% in the general population. It often has an early onset, frequently in childhood or adolescence and can become chronic and disabling. Reviews demonstrate that a lot of health care service and expense is spent on helping people to cope with OCD.[1] Further, people with OCD may be unable to work, making the illness an economic burden to themselves and their families, employers, and society.

Approximate Lifetime Prevalence: 2%

Diagnostic Criteria for Obsessions:

Recurrent and persistent thoughts, images or impulses that:

1. Are experienced as intrusive/unwanted.
2. Cause significant distress.
3. Are not excessive worries about real-life problems.
4. The person tries to ignore, suppress or 'neutralize'.
5. Are recognized as a product of the person's own mind.

Diagnostic Criteria for Compulsions:

Repetitive behaviours or mental acts that:

1. The person feels driven to perform in response to an obsession or according to rigid rules.
2. Are aimed at preventing or reducing distress or at preventing a dreadful event from occurring.
3. Are not realistically connected to what they are designed to neutralise or prevent, or are clearly excessive.

In adults, the obsessions or compulsions must:

1. Have been recognized as excessive or unreasonable at some point by the individual.
2. Cause interference in functioning, cause significant distress or take up excessive amounts of time.

In the 1950s, OCD was seen as a form of 'madness' and practitioners were told that people would have a psychotic breakdown if they were prevented from performing their compulsive behaviour. In the preceding example, Mia's repeated checking of locks and doors is compulsive behaviour.

In the decade that followed, a form of behavioural therapy intended for other kinds of anxiety disorders, called systematic desensitization, gave practitioners hope that people with OCD might be helped with behaviour therapy as well. In the 1960s and 1970s, the ground-breaking work of psychologists Victor Meyer and subsequently Jack Rachman and colleagues, led to the development of behaviour therapy for OCD that offered people an effective treatment for a previously "untreatable" problem. These investigators understood that the unwanted and disturbing obsessive thoughts made people immediately anxious and that the role of the compulsions was to reduce anxiety.

Consequently, they developed a form of treatment that involved gradual exposure to the triggers of the obsessional thoughts, and paired this with 'response prevention' (preventing the compulsive behaviours). This became the gold standard treatment for OCD. The 'cognitive revolution' of the 1980s led to the development of Cognitive-Behavioural Therapy (CBT) for the disorder. Today, practice guidelines recommend CBT as the psychotherapy of choice for OCD.[2]

1.0 The Content of the Therapy

A core ingredient of CBT for obsessional problems is exposing the individual to the situation (either real or imagined) that they fear or avoid, and preventing them from performing the compulsive behaviour. This treatment strategy, called 'exposure and response prevention' (ERP), appears to change behaviour as well as the beliefs people have about their compulsive behaviour.[3] In the example of Mia, she might be helped by encouraging her to go to sleep without checking the doors and locks repeatedly. With treatment, not only does she change her behaviour (that is, stop repeated checks of the doors and locks) but, by realizing that no harm comes to her or her children, she changes her belief that repeated checking is necessary to ward off harm.

Core ingredients of CBT treatment for OCD are:

- Exposing the individual to their feared situation/person/object for example, touching a door handle that is seen as 'dirty'. Exposure is usually gradual and frequently demonstrated first by the practitioner;
- Asking the person not to engage in the compulsion for example, washing hands; and
- Discussing with the person what they find out when they engage in exposure and response prevention for example, they discovered that their anxiety decreased within a couple of hours even though they didn't wash their hands or they discovered that nobody became ill from not washing their hands.

The treatment also typically involves explaining that everyone has unwanted intrusive thoughts, and that a key factor is how the person interprets these normal but intrusive thoughts. For example, interpretations such as 'this thought means that I'm responsible for preventing harm' or 'this thought means I'm dangerous' may lead to anxiety which the person tries to cope with by suppressing the thoughts, engaging in other thoughts or behaviours to counteract the thoughts, and avoiding or monitoring the environment for potential harm and danger. These coping efforts are usually unsuccessful and result in more persistent and frequent intrusive and misinterpreted thoughts.[4, 5]

CBT has been successful treating people with OCD individually and in groups. Group treatments can be successful whether individuals in the group have the same (for example, all with checking rituals) or different (for example, a variety of pure obsessions, washing compulsions and checking rituals) obsessions and compulsions.[6]

There is some evidence that individual CBT is superior to group CBT. Two large studies indicate that behaviour therapy (which focuses primarily on exposure and response prevention) and cognitive-behavioural therapy (which focuses on the interpretation of thoughts as well as the behaviour) are equally effective for OCD although cognitive-behavioural therapy may be better at treating co-occurring depression.[3, 7]

2.0 Effects on Symptoms in Different Populations

A recent study of 122 adult outpatients reported that 86% of those who completed treatment benefited from exposure and response prevention.[8] At least half of adults with OCD report that their disorder began in childhood. The childhood form of OCD is strikingly similar to that in adults. The Pediatric OCD Treatment Study of 112 volunteer outpatients aged 7-17 years, found that symptoms remitted for 53% of those in the combined CBT and medication treatment and for 39% of those undergoing CBT alone. Unlike with adults, there is some suggestion that a group CBT intervention that includes families is as effective in reducing OCD symptoms for children and adolescents as individual treatment.[9] Little is known about late-onset OCD or OCD in older adults.

OCD can take different forms and it may be worth distinguishing among different types or subtypes of the disorder. Compulsive hoarding appears to be a distinct subtype of the disorder. OCD with co-occurring tics also appears to be a distinctive subtype in which the disorder has an earlier onset, has a unique symptom picture, and does not respond as well to antidepressant medications.

3.0 Long-Term Outcome

There has been little good research on the long-term outcome of people with OCD who have been treated with CBT. A synthesis of studies (meta-analysis) of childhood OCD found that the younger the child when OCD began, the longer the child has lived with OCD, and whether the child required hospitalization predicted that the disorder would be more persistent. The presence of other psychiatric illness and a poor response to initial treatment also predicted worse outcomes.[10]

4.0 Pharmacological Options

Classes of medications (such as tricyclic antidepressants and selective serotonin reuptake inhibitors, or SSRIs) have demonstrated benefit in long-term treatment trials (at least 24 weeks) with some that can be used with children and adolescents. Available treatment guidelines recommend that an SSRI be tried first and continued for a minimum of 1-2 years before being very gradually withdrawn. Relapse is very common when medication is withdrawn, particularly if the person has not had the benefit of CBT (http://www.psychguides.com/oche.php).[11]

Other research reports that there are possible side effects, including apathy and increased suicide risk, associated with children and adolescents taking SSRIs; it is therefore important for individuals and families to weigh the risks and benefits of treatment with SSRIs carefully for children and adolescents.[12]

5.0 Combined CBT and Pharmacological Treatment

Combined treatments do not appear to be better or worse than CBT alone. However, combined CBT and medication does appear to be better than medication alone. For children and adolescents, CBT works as well as combined CBT and medication treatment and works better than medication alone. This latter finding has led to the conclusion that children and adolescents with OCD should begin treatment with CBT alone or with the combination of CBT plus medication. There is some evidence that the combined treatment reduces relapse when medication for OCD is withdrawn.[13]

6.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

In studies of people with obsessions, where those receiving CBT have been compared to those on a waiting list (not receiving any treatment, or only receiving support and attention), CBT has led to a superior outcome. These findings indicate that the effects of CBT are not merely a function of non-specific factors such as providing support and attention. Compared to other interventions, CBT has been found to be superior to relaxation training[14] but otherwise there have been few comparisons between CBT and other psychological interventions.

7.0 Brief Therapy and 'Rapid Responders'

Research comparing brief CBT treatment for OCD with a longer version of CBT has not yet been conducted. Anecdotal evidence suggests that while there are differences in individual responses to treatment, there are a small number of 'rapid responders' (people who respond rapidly to CBT). It may be that as CBT for OCD becomes more specific (for example, in targeting certain behaviours), shorter treatments can be developed.

8.0 Treatment Refractory OCD

Although the proportion of people classified as responders has been found to vary between 60-80%, this still leaves some who do not respond to treatment or who respond and do not experience a complete remission of their symptoms.[11] Furthermore, many people do not wish to engage in CBT as the prospect of exposure and response prevention is understandably frightening to them. In some cases, CBT delivered in a day-treatment program is necessary to treat severe and persistent OCD. In these programs, exposure can be provided for longer periods, which may be better for symptom reduction.

9.0 Self-Help and CBT

Self-help using the computer or interacting with an automated response system on the telephone has the potential to help when direct access CBT is not viable. A computerized program 'BT STEPS' has been designed by John Greist in the USA and Isaac Marks in the UK. BT STEPS is a self-therapy system to assess and treat OCD through exposure to the feared situation and prevention of obsessive and/or compulsive responses. It appears that this computer-guided, self-therapy program is effective in treating OCD, although clinician-guided behaviour therapy is likely to be even more effective. It also seems that a person's motivation to improve, and how quickly they completed the self-assessment, determines how much they are helped by the BT STEPS programs.[15]

10.0 What Predicts a Better Response to CBT?

There are few good quality research studies investigating prognostic indicators of a good response to CBT. Predictors of good outcome have included how much effort the individual puts into the treatment and how much insight they develop with regard to their difficulties. It has been suggested that people with a long history of poor response to medication may have poor insight into their disorder and/or not put sufficient effort into treatment, which could diminish treatment outcome.[16] Mataix-Cols and colleagues (2002) report that those who engage in hoarding tend to drop out prematurely and improve less.[17] The strongest predictor of outcome in this study was pre-treatment severity.

11.0 Role of the Family

It seems sensible to recruit relatives and family members (with the individual's permission) as helpers to treat OCD. One study demonstrated the benefits of family assistance in CBT treatment for OCD, as demonstrated by 61% reduction in symptoms for the family-aided group, versus 29% symptom reduction for the individual group.[18] Benefit from family involvement was not found, however, in another study that randomized 50 OCD patients to ERP (exposure to response prevention) homework with or without their partner being involved, where OCD severity fell by 33% in both groups.[19] These outcomes demonstrate possible benefits to involving family members in treatment (with individual's consent).

12.0 Summary

- CBT is the psychological treatment of choice for OCD.
- CBT requires specialized training to deliver.
- CBT is as effective as medication in treating OCD, although caution should be exercised when prescribing medication for children and adolescents.
- Individual treatment may be more effective than group treatments for adults, but this is not necessarily true for children (more research is warranted).
- Different therapies may be warranted for distinct subtypes of OCD for example, those with hoarding or tic disorders.
- Lack of insight may predict poor outcomes.
- Computerized and telephone-based versions of CBT may be useful first steps in the treatment of OCD.

CHAPTER 8 Obsessive-Compulsive Disorder (OCD)

Although she had lived with her disorder for many years, Mia decided to seek psychological treatment after a medical illness meant that she could no longer take her medication. The first group of sessions focused on exploring the bases of her beliefs; she was asked to recall past experiences that were both consistent and inconsistent with her view that she could cause harm to family. Gradually, she developed enough trust in her practitioner to attempt some of the exposure and response prevention tasks. These tasks included reading in bed, not repeating phrases and not seeking reassurance. The practitioner then came to Mia's home and touched all objects that she was afraid to touch due to her concerns that they somehow may be a 'bad omen'. On this visit, he also took her to a cemetery and asked her to touch a hearse. Doing these tasks and discussing the meaning of her concerns led her to gradually realize that she was not in danger of causing harm to her children. After such a long duration of illness, some behaviours were particularly difficult to change but overall she was able to overcome the most disabling features of her OCD.

Lorraine was a 25-year-old woman who played soccer for her country.

As part of her sporting activities, she was required to fly overseas for competitive matches. However, she was terrified of flying. Although she had flown on two occasions for important matches, she reported that she had become so anxious that she actually vomited. She was terrified of the airplane crashing, but also that she would embarrass herself by having a panic attack while flying. She had never enjoyed flying, but it had only become a problem in the past five years since she had been required to fly long distances.

1.0 The Content of the Therapy

Using Cognitive-Behavioural Therapy (CBT) to treat specific phobias involves graduated and prolonged exposure to the feared situation in a controlled way (for example, real or imagined exposure) so that people can see that the consequences they fear do not occur. The goal of treatment is to enable people to cope with the feared situation or object as they encounter them in the real world (for example, someone with a spider phobia after a course of CBT should be able to catch a spider with a glass and postcard and take it outside). Consequently, it is important to the effectiveness of the treatment that people understand that they will need to continue to expose themselves to the feared object or situation after the treatment session.

Approximate Lifetime Prevalence: 10-11%

Diagnostic Criteria for Specific Phobias:

For more than two weeks, five or more of the following symptoms are present (either depressed mood or decreased interest or pleasure must be one of the five):

- Marked and persistent fear that is excessive or unreasonable, triggered by presence or anticipation of a specific object or situation, for example, flying, animals, receiving an injection.
- Exposure to the feared object leads to anxiety that can take the form of a Panic Attack.
- The fear is recognized as excessive or unreasonable.
- The phobic situation is avoided or endured with intense anxiety.
- The fear or avoidance interferes significantly with normal functioning.
- In children, the duration is at least 6 months and the anxiety may be expressed by crying, tantrums or clinginess. The child may not recognise the fear as excessive.

Prior to the exposure session, the qualified CBT practitioner makes a list of the catastrophic beliefs that the person may have about the feared object or situation.[1] The exposure sessions are presented as a series of 'behavioural experiments' designed to challenge the individual's beliefs regarding the danger of the feared object. During the session, the individual is encouraged to approach the feared object or situation and to remain in it, or in contact with it, until anxiety is reduced to at least half its original level. For some phobias, particularly those involving fears of animals, the practitioner demonstrates how to interact with the feared object before the individual is encouraged to do so. Treatment for animal phobias, claustrophobia, dental phobia, flying phobia and height phobia all follow a similar protocol.

There is a one-session, rapid treatment for specific phobias that results in significant, long-term improvement for a percentage of individuals. This treatment, developed by Öst (1989) in Sweden, consists of intensive exposure to the feared situation or object during a single session.[2] The rapid treatment technique, used for the different specific phobias, led to improvement in 74% to 94% of people after 2-3 hours treatment.[1] In addition, treatment gains were well maintained at one-year follow-up.

2.0 Effects on Symptoms in Different Populations

Although we do not know whether CBT works equally well for people from different ethnic groups with specific phobias, some research has shown that African-Americans have twice the rate of specific phobias found in Caucasians or Hispanics.[3] Furthermore, although there is some variability across the different types of specific phobias, more women than men suffer from this disorder. Approximately 75-90% of individuals with animal and/or situational phobias and 55-70% of individuals with a phobia of heights, blood, injury or injections are women.

Fifteen percent of children referred for anxiety problems have specific phobias. CBT involving graduated exposure is effective for treating children with specific phobias between the ages of 7 and 17.[4] Parental attendance during treatment does not appear to affect treatment outcome. Exposure-based CBT for Hispanic youths with specific phobia is as effective as it is for Caucasian youths.[5]

Some specific phobias, particularly fear of flying, are difficult to treat using exposure because of the practical and economic challenges involved. For these types of phobias, the use of virtual reality exposure is more effective than no treatment and comparable to the success rates of exposure treatments in which the individual is actually exposed to the feared situation (for example, a flight in an airplane). Virtual reality exposure treatments have success rates, maintained at 6 month follow-up, of up to 93%.[6, 7] However, avoidance in an individual with a phobia should not be underestimated and treatment should continue to be elevated should avoidance continue.

3.0 Group Treatments

CBT for specific phobias is often conducted in a group format and results indicate that it works as well as it does when delivered individually.[8] No good quality direct comparisons between individual and group treatments have been reported.

4.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

CBT for specific phobias is clearly superior to no treatment at all. One session of exposure delivered by a qualified CBT practitioner is significantly more effective, post-treatment and at follow-up, than various forms of self-therapy: (a) following a manual at home with specific and structured directions, (b) following a manual providing only general information at home, and (c) following a manual providing only general information at a clinic.[9] Face to face exposure-based treatments for spider phobia in children have been found superior to other treatments such as eye movement desensitization and reprocessing (EMDR), and exposure treatment delivered by computer.[10]

5.0 Comparison with Pharmacological Interventions

Because specific phobias are so successfully treated with CBT techniques, medication alone is not usually prescribed for this disorder.

6.0 Self-Help and CBT

Self-help treatments using books or computers have been used and studied for specific phobias. Although self-help treatments are effective, they are much less effective than exposure-based treatment with a qualified CBT practitioner.[12] It is likely that in most clinical settings, people with specific phobias receive a few sessions of practitioner-assisted exposure in addition to self-exposure exercises for practice.

7.0 What Predicts Better Responses to CBT?

Little work has been done to determine if there are any factors that lead to better or worse outcomes with CBT for specific phobias. It may be because CBT is so effective that there has been little need to identify factors that help or hinder treatment. As is the case for other therapies and treatments, whether or not the person believes the treatment will work, and how motivated the person is to get better, affects the success of CBT.[11]

8.0 Role of the Family

Family members can play a role in a person's treatment by offering support. Learning about the phobia and about aspects of the CBT treatment may help the individual manage stress and stay calm and focused.

9.0 Summary

- CBT (including exposure), delivered by a trained practitioner, is the treatment of choice for specific phobias. For highly motivated people with mild to moderate levels of phobia, 75% to 95% exhibit no further symptoms of the phobia.
- CBT requires specialized training to deliver.
- Exposure-based treatments are also effective for children and adolescents.
- Treatment can be delivered effectively in groups or individually.
- Single session, exposure treatment for specific phobias is used successfully in clinical settings.
- Bibliotherapy (the use of self-help books/materials), virtual reality environments and computer-assisted self-exposure techniques are also beneficial.

Lorraine participated in a course of CBT. Her behaviour was analyzed on a one-to-one basis with a Psychologist prior to the group session. Her fear that "shock treatment" would be applied was alleviated, and her worry that she would not be able to endure the high level of anxiety she anticipated was addressed. The sessions started by discussing Lorraine's particular fears and physical symptoms of anxiety. Lorraine and her Psychologist collected the airline tickets together, and boarded the plane. The flight was one hour in duration. At their destination, Lorraine and the Psychologist disembarked and immediately checked in for the return flight. Although Lorraine had initially been skeptical about how such an intervention could be successful ('after all, I do actually fly'), the experience made her realize that she was able to control her anxiety, and that she was not in danger of going crazy or losing control on a flight. Psychoeducation regarding the probabilities of airplanes crashing was helpful, but continued exposure to short flights during which she felt she was in control was emphasized. She took several short flights with a friend prior to flying on her own. She described being "amazed" by the impact of the treatment and over time was able to fly to her matches overseas with only minimal discomfort.

Michael had always felt shy and awkward around other people.

His paternal grandfather had schizophrenia but Michael had been shielded from seeing him by his parents. When Michael was twelve years old, he had to change schools because of his father's job. He did not settle in with his new class, and he was an easy target for bullies. In his mid-teens he began to avoid going out and would refuse to leave his room for days on end. His parents became increasingly worried, but Michael refused any help. His parents began to notice that he was shouting to himself and he told them that he was hearing the voice of the devil. He saw a psychiatrist who diagnosed him with schizophrenia and prescribed anti-psychotic medication. He reported that this made the voices quieter and more manageable, but he still found it extremely stressful to go out of the house, especially when adolescent boys or men passed him on the street.

Cognitive-Behavioural Therapy (CBT) for schizophrenia developed during the 1990s as an adjunct to medication. Before this time, psychological therapy for schizophrenia was generally limited to behaviour therapy with inpatient populations and interventions with families to help reduce rates of relapse. CBT for schizophrenia developed largely in the United Kingdom, although recent trials have taken place in Canada, USA, Italy and The Netherlands. In total, around 21 randomized controlled trials of CBT for schizophrenia or schizophrenia spectrum disorders (for example, delusional disorder, schizoaffective disorder) have been completed.[1]

1.0 The Content of the Therapy

When delivered to people with schizophrenia, the main principles of CBT are followed, with some modifications. Perhaps one of the most challenging yet important principles is developing and maintaining a

Approximate Lifetime Prevalence: 1%

Diagnostic Criteria for Schizophrenia:

Symptoms: For a predominant part of at least one month, the patient has had 2 or more of:

1. Delusions (only one symptom is required if a delusion is regarded as 'bizarre').
2. Hallucinations (only one symptom is required if hallucinations are of at least two voices talking to one another or of a voice that keeps up a running commentary on the patient's thoughts or actions).
3. Speech that shows evidence of thought disorder, that is, incoherence, derailment.
4. Severely disorganized or catatonic behaviour.
5. Any 'negative' symptom such as flat affect, reduced speech or lack of volition.

Duration. For at least 6 months the patient has shown some evidence of the disorder. At least one month must include the symptoms of frank psychosis mentioned above.

Dysfunction. For much of this time, the disorder has impaired the patient's ability to work, study, socialize or provide self-care.

collaborative relationship with people who have difficulty engaging in relationships due to disordered thinking (for example, paranoia, delusional beliefs).[2] It is important that both the qualified CBT practitioner and the individual seeking treatment have a shared understanding of the illness and its causes and consequences. It is also important that the individual's delusional beliefs are treated with respect and empathy and addressed collaboratively. Similar to the exposure techniques used with other types of disorders, attempts are made to test disordered thoughts and beliefs, enabling the individual to gradually face feared situations and to begin to regard psychotic symptoms as less threatening. The individual seeking treatment is also helped to develop a more positive and stable sense of self and able to live a more self-directed life.

2.0 Treatment Populations

Research on the effectiveness of CBT for schizophrenia has included a variety of subtypes of schizophrenia and has assessed the effectiveness of treatment using a variety of measures. Most studies have focused on treatments for outpatients with chronic symptoms, although three studies have involved people hospitalized for an acute episode.[3, 4, 5] Another research focus has been on early intervention in which the early warning signs are recognized and treated.[6, 7, 8]

3.0 Effects on Symptoms

CBT for schizophrenia is usually delivered with individuals who have been stabilized on anti-psychotic medications. All of the studies reviewed have assessed the effects of CBT on the main or 'positive' symptoms of schizophrenia (that is, delusions and hallucinations). It is the positive symptoms that lead to hospitalization, but these are also associated with other symptoms of anxiety and depression. CBT produces modest reductions in the delusions and hallucinations typical of schizophrenia, but appears to be less effective in improving the 'negative' symptoms (for example, blunted affect, apathy). However, one study found that CBT was also moderately effective in alleviating negative symptoms.[9] Nevertheless, the effectiveness of CBT for schizophrenia is currently not as pronounced as its effectiveness with other disorders (for example, anxiety disorders, depression, substance use).

4.0 Effects on Relapse Rates

Two studies have shown that CBT can significantly reduce relapse of psychotic episodes.[7, 8] It appears, however, that when relapse prevention was not a focus of the CBT treatment, CBT had little effect on relapse.

5.0 Effects on Global Measures of Functioning

Schizophrenia is a disorder that significantly affects all areas of a person's life, including performance in work, school, home and leisure activities. Few studies have investigated the impact of CBT on more global outcomes such as quality of life and social functioning. At least one study indicates that CBT enhances global outcomes[8] but others show little impact.[10, 11]

6.0 Effects on Social Anxiety

Two studies have focused on reducing symptoms of social anxiety in schizophrenia using CBT delivered in a group format.[12, 13] Both studies found that CBT reduced social anxiety and improved quality of life compared to those waiting for treatment.

7.0 Early Intervention

One study has examined non-medicated individuals who were at extremely high risk of developing psychosis over a 12-month period.[11] CBT was a comparatively effective adjunct in preventing psychosis, reducing the need for the prescription of anti-psychotic medication, and in reducing psychotic symptoms. As medication is a hallmark treatment for schizophrenia, this initial study requires replication, but CBT appears to have promise as an early intervention.

8.0 Is CBT Superior to a Non-Specific Psychosocial Intervention?

Many studies of CBT's effectiveness in schizophrenia have compared individuals receiving CBT to those receiving supportive counselling or 'befriending'. Although these supportive treatments have also led to improvements in symptoms, CBT has been of more benefit, particularly when symptoms have been assessed at least a year after therapy has concluded.[9, 10] Supportive counselling tends to be unstructured and thus the effects are more difficult to assess. Further, supportive interventions alone may be inadequate in dealing with hallucinations.[4]

9.0 What Predicts a Better Response to CBT?

Factors that predict a good response to CBT in this population include a shorter duration of illness, less severe symptoms, few negative symptoms and a good working relationship as rated by the individual seeking help. One study found that the individuals who responded best to CBT were the ones who were able to consider the possibility that they might be mistaken about their delusional beliefs (that is, developing insight into their symptoms).[2] Examining and testing out beliefs is a key activity of CBT and it makes sense that those people able to do so would do best in this form of treatment. CBT should only be prescribed as part of a comprehensive treatment plan for schizophrenia.

10.0 Role of the Family

Although family therapy does not produce any improvement in symptoms for the individual, it can have an effect in preventing relapse in a sub-group of patients at high risk of relapse, as well as improving the individual's social support system.[1] Family therapy could therefore be an accompaniment to individual CBT for this sub-group of individuals.

11.0 Generalization to Clinical Settings and Stepped Care

While most studies have used clinical psychologists as practitioners, specially trained general psychiatrists and psychiatric nurses have also delivered CBT treatment successfully. At present, the exact degree of specialist training necessary to deliver CBT effectively for psychosis is not known. One study has demonstrated the effectiveness of CBT for psychosis in a community setting.[11]

12.0 Summary

- CBT for schizophrenia, in addition to medication, is somewhat effective in reducing positive symptoms such as hallucinations and delusions.
- CBT for schizophrenia has been less used and studied than CBT for anxiety disorders, depression, and substance use, therefore its effectiveness with this population is less well established.
- Further research is necessary to test whether CBT can improve quality of life and prevent the initial onset of psychosis.
- CBT requires specialized training to deliver.

Michael met with a cognitive behaviour practitioner for 20 sessions over six months. Initially, he was very difficult to engage and could only tolerate short sessions of around twenty minutes in his own home. He explained that he wanted to go out so that he could visit the record shop, but he was too afraid of being attacked by someone or threatened by his voices. The practitioner initially suggested that they could begin by walking along his local road, which was relatively quiet. If he saw or heard something dangerous then he could return home at any time and they could discuss it. Over time, Michael began to divulge more about his fears of leaving the house, which turned out not to come true when he challenged them. For example, when groups of men passed him on the street, they did not attack him as he had feared. By the end of therapy, Michael was going out for at least a short walk every day. He still heard the voices but he tended to consider his own plans first instead of doing exactly what the voices said.

Mary was a 15-year-old girl in public high school.

She became unhappy with her body, despite being of average height and weight for her age. Mary was frustrated by her dieting attempts since they had resulted in food cravings and binges due to intense hunger. Her girlfriends at school told her that she could be successful at weight loss by using laxatives and vomiting after eating. Mary and her friends began to plan purging activities and food binges together to prevent weight gain and satisfy their hunger. Eventually, it became increasingly difficult for Mary to focus on her schoolwork and she withdrew from many social activities. Her boyfriend recognized these changes in her personality and insisted she talk to the school nurse; Mary reluctantly conceded. A review of the medical history completed by the school nurse revealed recent fluctuations in Mary's weight. The school nurse recommended a referral for her to a mental health practitioner.

1.0 The Content of the Therapy

Eating disorders and disordered eating occur along a broad continuum of severity and complexity. There are currently two main types of eating disorders commonly recognized:

Anorexia

According to the American Psychiatric Association, an estimated 0.5 to 3.7 percent of women will experience anorexia in their lifetime.[1] Anorexia is an eating disorder where people starve themselves, become extremely thin, yet remain convinced that they are overweight. Anorexia typically starts in adolescence and is approximately 10 times more common in women than men. Anorexia is a life-threatening disorder and more than 10% of sufferers will die from it. There are only few, well-conducted studies of Cognitive-Behavioural Therapy (CBT) for the treatment of anorexia nervosa.[2] The UK National Institute for Clinical Excellence (NICE) Guidelines for the treatment of anorexia includes a range of interventions, often offered by a team of health care professionals[3], www.nice.org.uk/pdf/cg009quickrefguide.pdf. The range of interventions includes:

- Treatment of the medical complications of starvation;
- Nutritional counselling to establish a balanced diet, an expected rate of weight gain (up to 2 lbs. per week), and a final goal weight;
- Use of behavioural techniques to reward weight gain;
- Family therapy.

CBT for anorexia has not been sufficiently studied, and its effectiveness remains in question.[4] In fact, there are only a few well-conducted studies of CBT for the treatment of anorexia.[2] One such study compared [5] groups receiving 20 sessions of CBT, Interpersonal Psychotherapy (IPT), or clinical case management and support. The clinical case management group had superior results to both the CBT and IPT groups. However, 70% of participants did not complete treatment, or made only minimal gains.

CBT for anorexia is primarily used for:

- Treating any co-occurring psychological problems (for example, depression is a common problem co-occurring with anorexia); and
- Treating dysfunctional and inaccurate beliefs typical in anorexia (for example, "I am fat", "No one likes me") which contribute to anorexic behaviour and poor self-esteem.

More research is needed to discuss CBT as a viable treatment for anorexia itself. Thus, the bulk of this chapter will consider CBT for bulimia.

Bulimia

It is estimated that 1.1% to 4.2% of women will meet criteria for bulimia in their lifetime.[1] Bulimia is a disorder in which a person binges (eats massive quantities of food) and then purges (vomits or uses laxatives) in order to maintain a normal or lower body weight. In bulimia, it is not hunger that triggers bingeing. More likely, the person binges in response to symptoms of depression, feelings of stress, and low self-esteem. Bingeing and purging can quickly become a cycle of behaviours that is difficult to stop.

The studies that have looked at the effectiveness of CBT for bulimia show that it works better than other psychological interventions, and better than pharmacotherapy.[6] In the largest study to date comparing treatments, CBT reduced binge eating and purging behaviours by an average of 85% for those who completed treatment.[7] It also results in low rates of relapse – in other words, people with bulimia who are treated with CBT tend not to resume their disordered eating behaviour after treatment is completed.[8]

NICE (2004) recommends CBT as the treatment of choice for bulimia, which is the first time NICE has made an intervention-specific recommendation for a clinical disorder.[3] An important feature of CBT for eating disorders is that it be offered as 16 to 20 sessions over the course of four to five months. CBT treatment for bulimia is similar to CBT treatment for other disorders. It requires collaboration between the qualified CBT practitioner and individual and works by focusing on the factors and conditions that maintain the feelings, thoughts and behaviours that characterize the disorder. Treatment typically proceeds with two sessions per week during the first 3 to 4 weeks followed by weekly sessions and concluding with bi-weekly sessions. Treatment activities, for mild to moderate bulimia, include:

- Monitoring eating;
- Eating at regular, planned intervals;
- Introducing avoided foods to prevent binges;

- Teaching problem-solving strategies; and
- Addressing and changing the dysfunctional beliefs about body image, weight, and the self.

People with diagnoses of severe bulimia and/or concurrent bulimia and other disorders may require treatment for medical complications of their illnesses and the range of interventions included in the NICE guidelines.

There are a number of people who have disordered eating but who do not meet criteria for either anorexia or bulimia.[9] Half of the people who come to mental health care professionals for help will fall into this 'sub-threshold' category.[10] They may be people who have all the symptoms of bulimia but do not binge frequently enough to meet diagnostic criteria or people who vomit but do not binge. CBT treatment for people with sub-threshold eating disorders will be similar to treatment for those who meet the diagnostic criteria.

2.0 Effects on Symptoms in Different Patient Populations

The literature cites eating disorders occur frequently in young Caucasian women from industrialized countries. For half of these women, the disorder starts when they are younger than 18 years old; only 2 to 8% of all people with bulimia are male. More research is needed on the effectiveness of CBT for eating disorders in people of different ages, cultures or genders.

Certain sports and vocations put people at slightly more risk for developing eating disorders. These include ballet, modelling, cheer-leading, running, gymnastics, weight lifting, bodybuilding, jockeying, diving, wrestling, and figure skating. These sports and vocations either judge people on their body shape or require them to maintain a certain weight to perform or compete. It is the pressure to compete or perform – the success of which is determined by physical attributes and appearance – that can put young participants in these activities at risk.[11]

3.0 Effects on Relapse Rates

The majority of people with bulimia get better with CBT but symptoms will return for some people, no matter what kind of treatment they receive.[12] However, fewer people will experience a return of disordered eating symptoms when they are treated with CBT than when they are treated with other kinds of interventions.[3, 13, 14] Vaz (1998) suggests that, in order to prevent a return of symptoms, treatment should be more intensive (for example, more frequent sessions) when bulimic symptoms are more severe.[12]

Approximate Lifetime Prevalence: Women 1-3%; Men less than .5%

Diagnostic Criteria for Anorexia Nervosa:

Early signs may include withdrawal from family and friends, increased sensitivity to criticism, sudden increased interest in physical activity, anxiety or depressive symptoms.

(a) Refusal to maintain body weight at or above a minimally normal weight for height and age (for example, weight loss leading to maintenance of body weight less than 85% of expected; or failure to make expected weight gain during a period of growth, leading to body weight less than 85% of that expected);

(b) Intense fear of gaining weight or becoming fat, even though underweight;

(c) Disturbance in the way in which one's body weight and shape are experienced, undue influence of body weight or shape in self-evaluation, or denial of the seriousness of current low body weight; and

(d) In women who have reached puberty the absence of at least three consecutive menstrual cycles (that is, amenorrhea).

Approximate Lifetime Prevalence: Women 1-5%; Men less than .5%

Diagnostic Criteria for Bulimia Nervosa:

- Recurrent episodes of binge eating. A binge eating episode is characterized by both of the following:
  (a) Eating within a discrete period of time (for example, within any 2 hour period) an amount of food that is definitely larger than most people would eat in a similar time frame, and under similar circumstances; and
  (b) A sense of lack of control over eating during the episode (for example, a feeling that one cannot stop eating or control how much they are eating).
- Recurrent inappropriate behaviour to compensate following binge eating episodes to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
- The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.

4.0 Combined CBT and Pharmacological Treatment

When comparing CBT to antidepressant drugs for the treatment of eating disorders, Fairburn and Wilson (2002)[8] reached the following conclusions:

- People appear to prefer CBT over antidepressant medication;
- Fewer people drop out of CBT treatment than treatment with antidepressant medication;
- CBT works better than a single antidepressant drug resulting in more improvement upon treatment termination and more sustained improvement at long-term follow-up;
- The combination of CBT with antidepressant medication is more effective than medication alone; and
- The combination of CBT and antidepressants is not more effective at treating disordered eating behaviour than CBT alone but may be better at reducing co-occurring psychological problems such as anxiety and depression, which are often present in clients with severe and complex eating disorders.

5.0 Comparison with Non-Specific Interventions and Other Psychological Therapies

As mentioned CBT for anorexia does not compare favorably to case management and support.[6] However, CBT is effective in the treatment of bulimia and is as good or better than the other types of interventions to which it was compared. CBT has been effective in reducing bingeing and purging, but also in alleviating the psychological problems, such as anxiety and depression, which can co-occur with eating disorders. Interpersonal psychotherapy (IPT) is the leading alternative psychological treatment to CBT for eating disorders. However, IPT takes 8-12 months to be as effective as CBT, which typically requires only 3-4 months. Success with IPT for bulimia is attributed to the improvements people make to their interpersonal relationships and to associated increases in self-esteem.[7] Future research could examine any combined effectiveness of CBT and IPT.

6.0 Group CBT

Some people with eating disorders improve with group CBT, more so with bulimia than anorexia. People with very dysfunctional beliefs about themselves and their behaviour tend to do more poorly.[14] Other studies concur that more people will recover with individual CBT than with group CBT.[15] It would appear that individual CBT should be selected over group CBT particularly for those people with very dysfunctional beliefs, however, treatment gains can be made in group CBT.

7.0 What Predicts a Better Response to CBT with Eating Disorders?

A shorter duration of illness and younger age of onset and identification has been associated with better outcomes for those with eating disorders.[16] People with anorexia and their families often do not recognize the disorder, which makes treatment more difficult.[17] Fortunately, most people with bulimia admit they have a problem and often agree to engage in some type of treatment for it. As with other disorders, willingness to engage in treatment, and early positive responses to treatment tend to predict a better response and more positive outcomes.[18] Recent research has shown that an early reduction in the frequency of purging is associated with the best outcome at the end of treatment and at 8-month follow-up. Essentially, if CBT is going to work, it is likely to do so after 6 to 8 sessions. Some studies have shown that if people have concerns about shape and weight at the end of treatment, they are more likely to resume their disordered eating behaviours following treatment's end.[11] In these cases, individuals can be referred to more comprehensive programs for further treatment.

8.0 Treatment Refractory Eating Disorders

CBT is as effective, or more effective, than other treatments for bulimia. However, some people with eating disorders improve only slightly or not at all with any treatment.[19] People with very low self-esteem benefit least from CBT.[19] People with eating disorders very often present with co-occurring physical and psychological conditions, including but not limited to: dehydration, digestive problems, cardiac problems, renal failure, obsessive-compulsive disorder, anxiety, depression, substance

abuse, and personality disorders).[20] In one study, researchers found that those who completed a CBT program had fewer difficulties in trusting and relating to others than did those who dropped out of treatment.[21] Gleaves and Eberenz (1994) conducted a study in which approximately 71% of the women who did not improve with treatment reported a history of sexual abuse.[22]

9.0 Self-Help and CBT

Due to the complexity and severity of eating disorders, it may not be advisable to pursue a course of self-help as a person's only source of treatment. However, self-help manuals are an option for people with mild symptoms of disordered eating in the face of increasing demands for treatment. People using self-help manuals need to be highly motivated to succeed. Online versions of self-help manuals, where the person can submit progress reports to a qualified CBT practitioner via the internet, may be useful in reaching people who might not otherwise have access to help (for example, people who live in communities where no specialized treatment for eating disorders is available).

A new online self-help package for people diagnosed with bulimia has been developed and piloted by researchers at the University of Glasgow (http://www.rxpgnews.com/research/psychiatry/bulimia/article_712.shtml).[23] Initial trials of the first, stand-alone computerized treatment for people with bulimia have been successful and all people involved in the pilot have made significant improvements. The CD-ROM program proved particularly effective in reducing vomiting and laxative abuse. This success is important, as research has shown that an early reduction in vomiting is a good predictor of positive longer-term outcomes in the treatment of bulimia.

Some characteristics of bulimia, such as the shame and secretiveness about bingeing and purging, as well as the importance of self-control, may make self-help, computer-based treatment of particular appeal. Computer-based treatment, as compared to self-help manuals, can be individually-tailored and uses a variety of media and a mixture of teaching styles (for example, print materials and CBT exercises, videos) to facilitate learning and symptom management. Only three short sessions of

20 minutes of clinician time are required to introduce the use of the CD-ROM, compared with a typical individual treatment time of 10-20 hours. The intervention may have considerable potential for use in primary care and other health care settings either as a first step in bulimia treatment or for treatment of people with less severe disorders.

10.0 Role of the Family

Supporting the family as a whole is also an important component of treatment. Educating the family about disordered eating may help family members understand what an individual is experiencing and may clarify how best that they can help. Moreover, support services may continue after discharge, including, for example, outpatient therapeutic meal support groups.

11.0 Summary

- There is little research into the effectiveness of CBT for anorexia.
- CBT is the leading psychological intervention for bulimia.
- An important goal of CBT is to change an individual's dysfunctional beliefs about his/her shape, weight, and self.
- CBT requires specialized training to deliver.
- CBT is as, or more, effective in the treatment of bulimia than are other treatments like pharmacotherapy and works as well on its own as it does when delivered with other treatments (especially during early interventions and when disorders are of mild to moderate severity).
- For clients with complex and severe eating disorders, a comprehensive multi-disciplinary assessment is especially important together with an appropriate range of interventions, which can include individual and group CBT (See NICE guideline[3]).

After seeing the school nurse, Mary went to see a psychologist that specialized in eating disorders. Through the course of treatment, Mary and the psychologist pre-planned her meals and paced her eating. Having a schedule helped Mary to reduce the frequency of purging and using of laxatives. The psychologist also showed Mary images of young women of a range of body types and used a rope to estimate her own size in comparison. Mary was surprised to see that she routinely overestimated her own weight and size. They also discussed her thoughts and feelings on her developing body. She maintained a log and she learned that there were certain situations in which she felt more compelled to binge, particularly when she felt stressed or nervous. She recognized that bingeing and purging were not the best ways to deal with these situations, and she began working with her Psychologist to develop alternative ways of coping, including regular exercise. Her weight remained stable throughout treatment, which Mary found encouraging. After six months of treatment, she had not binged or purged for 7 weeks; Mary reported "feeling better".

CHAPTER 12 Stepped Approach to Care and Alternative Ways to Delivering CBT

A Stepped approach to care is designed to increase the efficiency of clinical services by targeting treatment that is proportional to the level of need. There is a disorder severity gradient and treatment is thus also graded. Specifically, those with milder symptoms are more able to fend for themselves via the internet, self-help groups or with printed materials. People may seek treatment at mild to moderate levels of severity, but more commonly when they are in "crisis". At lower levels of need, less intensive interventions may be offered, with more complex and intensive forms of treatment following increased needs. A stepped or graded approach has the capacity to improve access to Cognitive-Behavioural Therapy (CBT) by increasing the availability of less intensive interventions for individuals with less severe presenting problems, while focusing more intensive treatments on the subset of individuals who need them. Resources and additional treatment modalities are needed to serve those at both the higher and the lower end of the severity continuum. A stepped approach emphasizes the importance of early detection, accessibility of services, public education, and continuity of care.

A large number of CBT interventions involve 16 to 24 sessions of face-to-face, one-to-one contact (spanning two months to one year) with a qualified CBT practitioner. The nature of alternative interventions varies widely, including the following:

- Group CBT, including psychoeducation
- Self-help groups
- Brief, individual CBT consisting of 1 to 4 sessions
- Telephone-assisted CBT
- Guided Self-help books
- Audio and Video tapes
- Internet-assisted CBT
- Computer-assisted CBT

Practitioners should have an awareness of the potential benefits and limitations of self-help materials for mental health problems. This awareness may be particularly important for health care professionals who are not experts in Cognitive-Behavioural Therapy (CBT). Also, anyone using self-help materials should be encouraged to discuss them with his or her primary health care provider.[1]

Each of these modified forms of CBT is summarized in Table 1, along with the circumstances in which there are data to support their efficacy. Often these formats are combined, for example brief CBT supported by a self-help booklet. The interventions are generally directed at individuals with mild to moderate, but not severe, psychopathology. They are most effective with the disorders in which dysfunctional beliefs can be identified and addressed (for example, a person with panic disorder believing that his racing heart means he is on the brink of having a heart attack).[2]

The graded or stepped approach aspires to assign people to the level of intervention that their symptoms warrant. Careful treatment planning is always recommended before prescribing a "lower-level" intervention.

At present there are few established criteria on which to make these assignments, although the following should be considered:

- Research supports the use of the intervention for the mental disorder at the level of severity and complexity presented by the person.[3]
- The individual is willing and able to engage in the intervention (for example, she has a computer for computer-assisted CBT; reading skills to use self-help booklet).
- The individual is not being denied a higher level and needed intervention that is available at present.
- The individual is prepared to undertake a more intensive level of care if the current "step" or "grade" is not sufficiently effective.

Description of CBT Forms

Modified Forms of CBT	Descriptions of CBT forms	Examples of Disorders (primarily mild to moderate severity) in which CBT has been evaluated
Group	Groups of around 4 to 8 individuals with related presenting problems meet regularly with a CBT practitioner for around 6 to 16 sessions	Anxiety Disorders, Depression, Eating Disorders, Insomnia, Somatization Disorders, Psychotic Disorders
Brief /Brief Intensive	Between 1 and 10 sessions, depending on the disorder. Brief intensive CBT involves similar number of sessions to standard CBT but condensed into a period of less than two weeks	Specific Phobias, Panic Disorder (with or without Agoraphobia), Depression, Eating Disorders, Somatization Disorders, Psychotic Disorders
Other trained health care professionals	Health care professionals receive training and ongoing supervision to administer CBT, usually in a brief format, or focusing on specific components, for example, problem-solving	Depression, Somatization Disorders, Insomnia, Psychotic Disorders, Panic Disorder, Post-Traumatic Stress Disorder (PTSD)
Telephone-assisted	After face-to-face assessment, therapy involves communication via telephone	OCD, Depression, Insomnia
Guided self-help book	After face-to-face assessment, therapy involves the structured use of self-help book (often supplemented by video & audio tapes) that is regularly monitored	Anxiety Disorders, Depression, Eating Disorders (not Anorexia Nervosa), Insomnia, Chronic Fatigue, Alcohol Problems
Internet-assisted	After face-to-face assessment, therapy involves an interactive website or communication with the practitioner via the internet or email	PTSD, Depression, Somatization Disorders, Eating Disorders, Panic Disorder
Computer-assisted	After face-to-face assessment, therapy involves use of an interactive computer program that provides psychoeducation and promotes change in thinking and behaviour	Specific Phobias, Panic Disorder, Mixed Anxiety Disorders, Depression, Eating Disorders

IMPORTANT NOTICE: Resources compiled below include a wide range of materials for better understanding Cognitive-Behavioural Therapy (CBT) and mental health. As with the rest of this Guide, information may be of use or interest to consumers and their families, as well as health care professionals (both those qualified and not qualified to administer CBT). Use of these resources does not provide the qualification to competently conduct CBT in the absence of further education, training, supervised experience, or appropriate professional experience.

1.0 Websites

www.aabt.org/clinical/clinical.htm#aabt – The Association for Advancement of Behaviour Therapy's (AABT) Clinical Directory and Referral Service. This service is offered to help the general public locate a behaviour or cognitive behaviour therapist in their area (including Canada).

www.academyofct.org – The Academy of Cognitive Therapy was founded by Aaron T. Beck, who is credited with originating cognitive therapy in the early 1960s. Its members are among the leading international figures in the science and practice of CBT. The website emphasizes the importance of appropriate training and links to courses and workshops around the world, and publishes a regular newsletter.

www.anxietybc.com – The Anxiety Disorders Association of British Columbia works to increase awareness about anxiety disorders; promote education of the general public, affected persons, and health care providers; and increase access to evidence-based resources and treatments.

www.babcp.com – The British Association of Behavioural and Cognitive Psychotherapies is the UK organization for CBT therapists. It is responsible for formally accrediting CBT practitioners, organizing annual conferences and providing support to over 6,000 members. The website includes information about UK and international CBT conferences, and pamphlets for patients on a range of psychological disorders.

www.camh.net – Centre for Addiction and Mental Health in Toronto, ON is Canada's leading mental health and addictions teaching hospital.

www.cognitivetherapy.com – An informational website containing CBT resources such as training opportunities, links, and a directory of therapists.

www.healthyplace.com – HealthyPlace.com is a large consumer mental health site, providing comprehensive information on psychological disorders and psychiatric medications from both a consumer and expert point of view.

www.heretohelp.bc.ca – A mental health information site by the BC Partners for Mental Health and Addictions Information.

www.mentalhealth.com – This site provides information about different mental disorders, diagnosis, medication, and research. Information on CBT is given for several mental disorders.

www.mentalhealthcanada.com – Searchable Canadian Directory of Mental Health Professionals.

www.mgh.harvard.edu/madiresourcecenter/moodandanxietyvideos.asp – Massachusetts General Hospital, Mood and Anxiety Disorders Institute – this website is a general resource for information on Mood and Anxiety Disorders. Of particular relevance are two online presentations by Dr. Michael Otto, Associate Professor of Psychology, Harvard Medical School, and Director of the Cognitive-Behavior Therapy Program at Massachusetts General Hospital. In one video, he explains CBT for anxiety and mood disorders and in a second video he explains CBT for schizophrenia.

www.mind.org.uk/Information/Booklets/Making+sense/MakingsenseCBT.htm – Produced by Mind.org in the UK, this fact sheet outlines what CBT is, how it works, and how to find a therapist.

www.MindOverMood.com – Center for Cognitive Therapy provides resources for the public from Christine Padesky, an international leader in cognitive-behaviour therapy, author of several highly influential books on CBT, and Founder of the Center for Cognitive Therapy in Huntington Beach California. Her professional website (www.padesky.com) provides written and video/audio training materials for health professionals, and information about consultation and upcoming international workshops.

www.mooddisorderscanada.com – The Mood Disorders Society of Canada (MDSC) is a national, not-for-profit, volunteer-driven organization that is committed to improving quality of life for people affected by depression, bipolar disorder and other related disorders.

www.nacbt.org/basics-of-cbt.htm – The National Association of Cognitive-Behavioural Therapists offers a training course in CBT for mental health professionals.

www.nice.org.uk – The National Institute of Clinical Excellence (UK) is an organization created as part of the National Health Service in the UK. Its mandate is to systematically evaluate the state-of-the-art in treatment research and make specific guidelines for clinical practice for health authorities within the UK. While its guidelines cover a wide area, many have specific relevance for the practice of CBT. In particular, there are published guidelines for Unipolar Depression, Generalized Anxiety and Panic Disorder, PTSD, and Schizophrenia, and an evaluation of Computer-Assisted Treatments for Depression and Anxiety. Treatment guidelines for Bipolar Disorder are in development.

www.octc.co.uk – The Oxford Cognitive Therapy Centre is the leading CBT training course in the UK. The website provides information on CBT-related publications by members of the training staff and a wide range of CBT self-help guides for service users.

www.psych.ubc.ca/clinic – The UBC Clinical Psychology Program provides graduate student therapists at subsidized rates to treat individuals and groups. Treatment services integrate the latest research on psychotherapy, and emphasize cognitive-behavioural and interpersonal therapies. Most services are offered in the form of individual therapy, however, group treatment may also be offered depending on the frequency of referrals for particular problem types.

www.psychdirect.com – PsychDirect is a website that provides evidence-based mental health education and information.

2.0 Videos, DVDs, and Audiotapes

www.apa.org/videos/cognitive.html – Persons, J.B., Davidson, J., & Tompkins, M.A. (2000). Titles include: Structure of the therapy session, Activity scheduling, Individualized case formulation and treatment planning, Using the Thought Record, and Schema change methods. In J.B. Persons (Producer, Director) Cognitive-behavior therapy for depression [Videotape series]. Washington, DC: American Psychological Association.

www.apa.org/videos/4310460.html – Layden, M. A. Cognitive therapy for borderline personality disorder. [Videotape series]. Washington, DC: American Psychological Association.

www.people.man.ac.uk/~mdphwnj/videos.htm – Harrington, R., & Verduyn, C. Titles include CBT for Depressed Adolescents and CBT for Anxiety in Adolescents. Nick Jordan, Video Producer, School of Psychiatry & Behavioural Sciences, 2nd Floor, Education & Research Centre, Wythenshawe Hospital, Manchester M23 9LT, UK. Nick.Jordan@man.ac.uk

www.padesky.com – Padesky, C. (2004). Titles include: Constructing new underlying assumptions and behavioural experiments, Constructing new core beliefs, Cognitive therapy for panic disorder, Collaborative Case Conceptualization, Guided discovery using Socratic dialogue, Testing automatic thoughts with thought record, CBT for anxiety disorders, children, couples, depression, dissociative disorders, Fundamentals of cognitive therapy, Groups, Mind over mood, Personality disorders.; Center for Cognitive Therapy, PO Box 5308, Huntington Beach, CA 92615-5308 USA.

3.0 Training Courses and Workshops

American Institite for Cognitive Therapy, New York.
www.cognitivetherapynyc.com

Assumption College: The Aaron T. Beck Institute in Cognitive Studies, Worcester, MA.
www.assumption.edu/nhtml/gradce/grad/coun_psych/beck.php

Atlanta Center for Cognitive Therapy, Atlanta, GA.
www.cognitiveatlanta.com

Beck Institute for Cognitive Therapy and Research, Philadelphia, PA.
www.beckinstitute.org

Center for Cognitive Therapy, Huntington Beach, CA.
www.padesky.com

Center for Cognitive Therapy, Philadelphia, PA.
www.uphs.upenn.edu/psycct/edu/index.htm

Cleveland Center for Cognitive Therapy, Cleveland, OH.
www.behavioralhealthassoc.com/About_BHA/Educational_Programs/educational_programs.html

Oxford Cognitive Therapy Centre, Oxford, UK.
www.octc.co.uk

4.0 Evaluated Computer Software to assist in CBT Treatment

Beating the Blues. Sovereign Publications Ltd.
www.sovereign-publications.com/ultrasis.htm
Ultrasis UK limited, 2nd Floor, Northburgh House,
10 Northburgh Street, London EC1V 0AT.

Calipso - Calipso produces mental health training materials for health care professionals and self-help materials for use with patients.
www.calipso.co.uk/mainframe.htm

CLIMATE - Computer-aided CBT program from Dr. Gavin Andrews at the Clinical Research Unit for Anxiety and Depression – Australia –
www.climate.tv

FearFighter. ST Solutions Ltd. Computer-aided CBT program developed by Stuart Toole and Professor Isaac Marks. –United Kingdom.
www.fearfighter.com/TEST/AboutFFintroduction.htm

Good Days Ahead: The Interactive Program for Depression and Anxiety (Client and Professional Versions). Jesse H. Wright, M.D., Ph.D., Andrew S.Wright, M.D., & Aaron T. Beck. (2004).
www.mindstreet.com

MoodGYM Training Program. Software program helping with implementing exercise program to beat mental disorders from The Australia National University.
moodgym.anu.edu.au.

StressPac. White, J. (1997). A detailed program for stress related problems.
www.harcourt-uk.com

5.0 Books and Treatment Manuals

General

Beck, J. S. (1995). *Cognitive Therapy: Basics and Beyond.* New York: Guilford Press.

Beck, A. T. (1976). *Cognitive Therapy and the Emotional Disorders.* New York: Penguin.

Bennett-Levy, J., Butler, G., Fennell, M., Hackmann, A., Mueller, M., Westbrook, D., & Rouf, K. (2004). Oxford Guide to Behavioural Experiments in Cognitive Therapy. Oxford, UK: OUP.

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Bipolar Disorder: Therapy Manuals

Basco, M. R. & Rush, A. J. (1996). *Cognitive-behavioral therapy for Bipolar Disorder.* New York: Guilford Press.

Lam, D.H., Jones, S., Hayward, P. & Bright, J. (1999). *Cognitive Therapy for Bipolar Disorder: A Therapist's Guide to the Concept, Methods and Practice.* Chichester, UK: Wiley and Son Ltd.

Newman, C. F., Leahy, R. L., Beck, A. T., Reilly-Harrington, N. A., & Gyulai, L. (2002). *Bipolar Disorder: A cognitive therapy approach.* Washington, DC: American Psychological Association.

Anxiety Disorders: Treatment Manuals

Barlow, D. (2004). *Anxiety and Its Disorders: The Nature and Treatment of Anxiety and Panic.* New York: Guilford Press.

Wells, A. (1997). *Cognitive Therapy of Anxiety Disorders: A Practice Manual and Conceptual Guide.* Chichester, UK: Wiley.

Social Phobia: Treatment Manuals

Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. In R. Heimberg, M. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), Social phobia: Diagnosis, assessment and treatment (pp. 69-93). New York: Guilford Press.

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PTSD: Treatment Manuals

Foa, E. B. & Rothbaum, B. O. (1998). *Treating the Trauma of Rape: Cognitive-Behavioral Therapy for PTSD.* New York: Guilford Press.

PTSD: Reviews of CBT Treatment

PTSD Guideline Development Group (2005). *The management of PTSD in primary and secondary care.* **www.nice.org.uk**

Rothbaum, B. O., Meadows, E. A., Resick, P., & Foy, D. W. (2000). *Cognitive-behavioral therapy. In Effective treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies* (Eds E. B. Foa, T. M. Keane & M. J. Friedman), pp. 60–83. New York & London: Guilford Press.

Foa, E. B., Keane, T. & Friedman, M. (2000). *Effective treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies.* New York: Guilford Press.

Psychosis: Therapy Manuals

Chadwick, P., Birchwood, M., & Trower, P. (1996). *Cognitive therapy for delusions, voices and paranoia.* Chichester, UK: Wiley.

Fowler, D., Garety, P., & Kuipers, E. (1995). *Cognitive Behaviour Therapy for Psychosis: Theory and Practice.* Chichester, UK: Wiley.

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