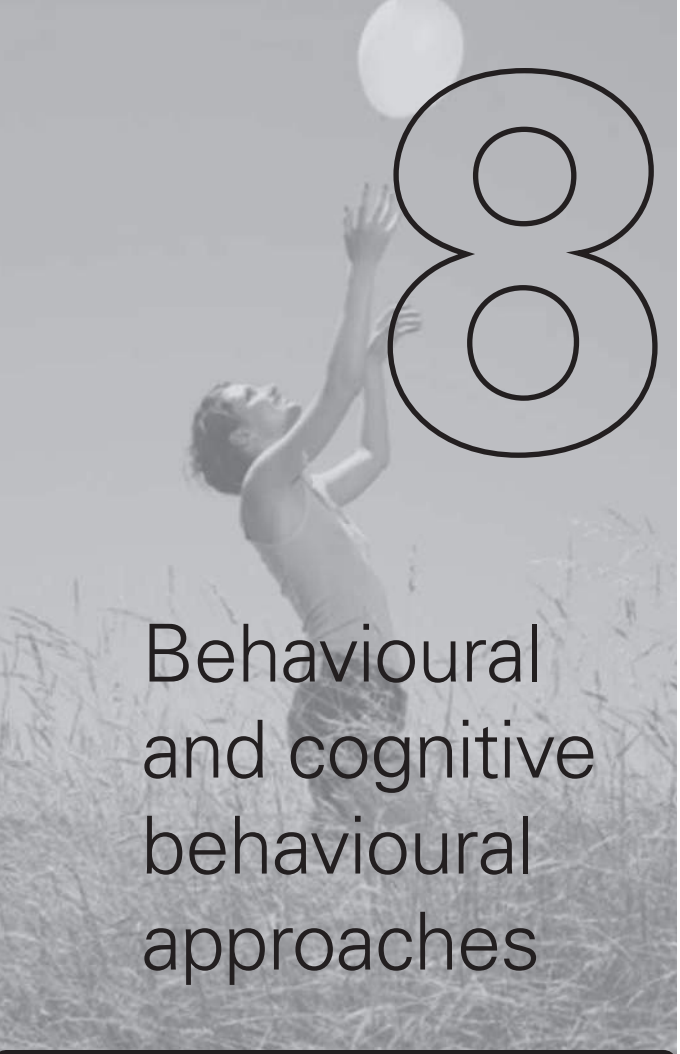

8

Behavioural and cognitive behavioural approaches

INTRODUCTION

In Chapter 2 we identified the major theoretical approaches to counselling from which all the contemporary models described in this book have evolved. Of the three perspectives – psychodynamic, humanistic and behavioural – only the behavioural school, and the approaches derived from it, remain to be discussed in more detail.

Many of the counselling models we have looked at are concerned to describe the internal or unseen characteristics said to govern human behaviour. The structure of personality outlined by Freud, and the actualising tendency or potential for growth which both Rogers and Maslow upheld, are firmly located within the person. In contrast to this, the behavioural tradition looks at overt behaviour and the processes whereby human learning takes place. Within recent years another important dimension – the cognitive – has been added to the behavioural tradition. While the focus remains on outward behaviour, there is an increasing emphasis on internal or covert human behaviour as well. This new focus has occurred because behaviour therapists have gradually recognised the significance of thinking, reasoning and other cognitive processes in determining a person's actions and behaviour.

In this chapter we shall consider both the behavioural and cognitive approaches, with special reference to the principles of experimental psychology and their application to therapy and counselling. The work of Albert Ellis, and the cognitive approach (now called Rational Emotive Behaviour Therapy) which he pioneered, will also be discussed in some detail.

Evolution of behaviour therapy

Behaviour therapy has evolved from the theories of human learning which were formulated at the beginning of the twentieth century. The first studies of learning took place in the laboratory and animals, not humans, were used in the experiments. In order to understand the theory and practice of behavioural counselling and therapy, it is necessary to appreciate the relevance of the research which prompted this approach. In the following section we shall consider some of the main contributors in the field of learning theory. Important names include

Pavlov, Watson, Thorndike and Skinner, although other psychologists have also contributed their ideas and research in this area.

Ivan Pavlov and classical conditioning

Ivan Pavlov (1849–1936) was a Russian psychologist whose main area of study was the digestive system. In the course of his work he observed that dogs would salivate at the sight of food, an observation which led eventually to the concept of 'Classical conditioning'. Pavlov's dogs appear to have learned that the appearance of an assistant carrying a tray meant they were going to be fed. In the ordinary course of events dogs will salivate when they smell or taste food, a response known as an 'unconditioned reflex'. However, Pavlov showed through further experiments that it was possible to condition the animals to salivate when they heard the sound of a bell prior to eating. In the final part of his experiment Pavlov demonstrated that his dogs would salivate at the sound of a bell, which he called the 'conditioned stimulus', even when no food followed. This proved to him that the animals had 'learned' to associate the bell with the food, also known as the 'unconditioned stimulus'. Pavlov called this sequence of events the 'conditioned response'. This 'associative learning' offers some explanation about the way humans respond in certain situations too. The development of a phobia can be illustrated in the light of Pavlov's theory, as the next example shows.

CASE STUDY Vanessa

Vanessa, who was five years old, liked furry toys and stories about animals. In the context of classical conditioning, the toys and stories are the 'unconditioned stimulus', while the pleasure she derived from these is known as the 'unconditioned response'. On a number of occasions Vanessa was taken to visit friends in the country who owned a large and rather noisy dog. After a period of time she began to fear the dog, especially when it came close to her and barked aggressively. Eventually the dog became, for her, a 'conditioned stimulus' that was then linked to the 'unconditioned response' of fear in the face of aggression.

Over a period of time all dogs and furry animals became the 'conditioned stimulus' which then produced the 'conditioned response' of intense anxiety (see Figure 8.1). This maladaptive response extended itself over a period of time, so that Vanessa was unable, in the end, to derive any pleasure from her toys or stories about dogs and other furry animals. This latter effect is called 'stimulus generalisation' and occurs when a stimulus which is similar to the original one (in Vanessa's case the barking dog) is encountered. Conditioned responses vary in other ways too, including the following:

Stimulus discrimination

Vanessa's response to the dog extended itself to other dogs and furry animals. However, it did not develop into a fear of birds because she was able to identify these as belonging to another species. Pavlov's dogs were also able to discriminate and after a while responded only to the specific bells which were used to condition them.

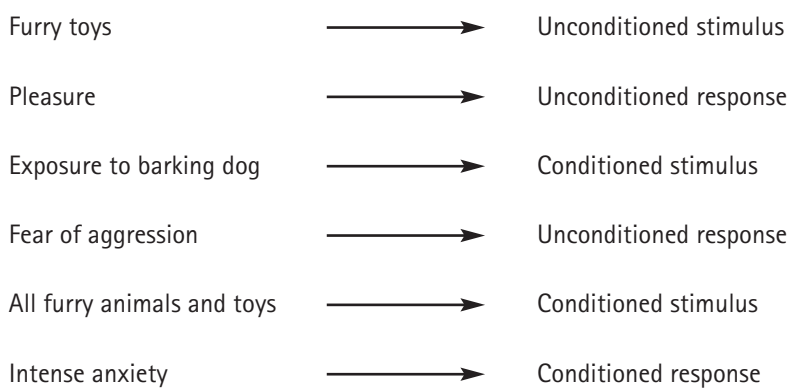

Figure 8.1 Development of a phobia

Stimulus extinction

When responses are not reinforced, at least occasionally, they will cease eventually. The total elimination of a response is known as 'extinction'. Again, Pavlov proved this in his experiments with dogs. When a bell was repeatedly rung without any appearance of food, they simply stopped salivating.

Spontaneous recovery

However, even when a response has been extinguished, it can be reactivated. This happens at a later date when the conditioned stimulus is presented once again. Pavlov's dogs began to salivate at the sound of a bell, which was rung long after their learned response had been 'extinguished'. This response suggests that they had retained some memory of the association between food and the bell.

Phobias

It is important to link Pavlov's research and findings to the actual practice of behavioural counselling and therapy. If this connection is not made, the theory of classical conditioning tends to appear almost meaningless in the human context. Pavlov's work was carried out on animals, but it does have direct application to human behaviour and to some of the psychological problems people experience. The case study of the five year-old Vanessa serves to illustrate the significance of learning theory in relation to phobias and the way they develop. Phobias are strong

EXERCISE

Individual phobias

Working in pairs, look at the following list of phobias and discuss ways in which you think they may have developed.

Fear of:

- the dark
- spiders
- public speaking
- going out
- being alone
- cats
- flying
- snakes
- confined places
- blood.

These are some of the most commonly experienced phobias, but it is possible to develop specific fears about almost anything. Do you have a specific phobia, not included in this list? If so, say how you think you may have acquired it and in what ways, if any, it bothers you in everyday life.

irrational fears, which interfere with a person's ability to cope with everyday life, and they are remarkably common. Later in this chapter we shall look at ways of helping clients overcome their phobias. However, classical conditioning has application to other conditions too. People with high blood pressure, for example, may have been conditioned by stressful events, either at work or in the home environment. This is also true of other stress-related illnesses, like skin conditions such as eczema and ulcers.

J. B. Watson (1878–1958)

While Pavlov was conducting his research in Russia another psychologist, J. B. Watson, was involved in similar work in America. Watson's contribution to learning theory extended beyond animal experiments and at one stage he actually conditioned a small child to fear a pet rat. This was achieved by frightening the child with a loud noise each time he played with the animal. In the long term this fear was extended to furry toys and even fur coats. Watson's work supported the view that human emotional response, like phobias, are indeed the result of conditioning. If we accept that this is the case, then it seems logical to suppose that conditioning can be reversed through a process of unconditioning. Such a process is fundamental to many of the methods traditionally used in behaviour therapy. It should be added, however, that the behavioural viewpoint offers one explanation about the cause of phobias. The Freudian or psychodynamic interpretation is quite different, and suggests that the phobic object represents an impulse, wish or part of the Self which is unacceptable to the individual (Rycroft, 1972).

E. L. Thorndike and the law of effect

Learning theory was enhanced by the work of another American psychologist, E. L. Thorndike (1874–1949) who also carried out work with animals. Thorndike formulated the 'law of effect' which states that when a response to a specific stimulus is followed by a reward, the bond between the stimulus and the response will be strengthened. On the other hand, when the response is followed by a negative outcome, the bond will be weakened. Thorndike's research enhanced the status

of learning in psychology, and showed that it is possible to predict behaviour through an understanding of its laws. In simple terms, we could say that a satisfying experience is one which induces movement towards it, while an unsatisfying experience has the opposite effect. Behaviour is therefore dependent on its consequences, which may be either rewards or punishments.

B. F. Skinner and instrumental learning or operant conditioning

Thorndike's law of effect was developed further by B. F. Skinner (1904–1990) whose work on 'operant conditioning' was conducted in the 1930s. Skinner, who was born in Pennsylvania, carried out much of his research at the University of Minnesota. He first used the word 'reinforcement' in connection with animal experiments. In order to ensure that responses will be repeated, an animal needs to be rewarded so that its behaviour is reinforced. Skinner's laboratory animals learned by trial and error that there is a link between behaviour (for example pressing a lever) and the reward (for example food). If a certain type of behaviour leads to discomfort however, or an expected reward is not forthcoming, then the behaviour becomes less likely in future.

Skinner identified two kinds of reinforcers: positive and negative. As far as animals are concerned, positive reinforcement is usually food. In relation to people, food and material comforts can act as reinforcers. Negative reinforcement for animals involves the removal of discomfort when a correct response is made. The same principle of negative reinforcement applies to humans as well. A person under stress might, for example, take up exercise in order to reduce pressure – both mental and physical. If this course of action is successful, then it is likely to be repeated in the future when stress levels rise. The principle of reinforcement is important in relation to behaviour therapy, as we shall see later in this chapter.

Application to practice

While classical and instrumental learning can be separated in theory, they are not, as Richards and McDonald (1990) point out, as easily segregated in practice. Both viewpoints have, however, contributed a great deal to our understanding of the way certain human behaviours originate and are perpetuated. The establishment of more desirable forms of behaviour (a fundamental goal of behavioural counselling) becomes possible once we appreciate the principles of reinforcement.

The conclusions drawn by both Thorndike and Skinner leave very little room for the concept of free will or choice, and they certainly reject the Freudian idea of personality structure or any other mental

entities which might affect behaviour. Instead, Skinner in particular subscribed to the view that all behaviour is 'determined' by stimulus-response associations beyond the conscious control of the individual. In addition to this he placed little value on rationality as an explanation for human behaviour. It is important to remember that in learning theory the principles of behaviour apply to animals as well as people. So rationality is certainly not stressed or even acknowledged. As Phares (1988) indicates, such a view leads to the corollary belief that 'behaviour can be controlled'. Whether or not we agree with these strict behaviourist ideas, we can at least learn from them. It is probably true to say that in the history of psychotherapy a great deal of emphasis has been placed on the inner life of the person, without too much attention being focussed on overt observable behaviour and its environmental influences. The work of the behavioural psychologists has served to redress this balance. In Skinner's opinion 'almost all our human problems involve human behaviour' (Skinner, 1971) – a view which is difficult to dispute.

Social learning theory

Another group of psychologists, the social learning theorists, also accept that human learning takes place according to the principles of reinforcement and punishment. However, they go beyond this and suggest that children learn from others too, through the process of observation and imitation. Children who observe others being punished for certain behaviour, for example, are unlikely to engage in that behaviour themselves. By the same token, behaviour which is clearly rewarded in others is likely to prompt imitation in the hope of similar rewards. The social learning theory of Albert Bandura (1977) helps to explain how people acquire complex behaviours in social settings. For Bandura, both the psychodynamic and learning theory approaches are limited in their assessment of human behaviour because they do not pay sufficient attention to this important social dimension. Bandura's position makes so much sense that it is difficult to see how it could possibly have been overlooked.

Observational learning

By observing others we learn to do things we were unable to do before, but according to Bandura, who was born in 1925, the behaviour we observe is already in our repertoire. The effect of observation is to encourage us to do that which we know anyway. In this instance, the role of the model is a 'facilitative one' (Phares, 1988). This last point is important since it links Bandura's theory to the practice of therapy, and in particular to the use of 'modelling' as a technique in the behavioural approach. This is a point we shall explore later in this chapter.

Bandura's experiments support the idea that learning may take place through a process of 'vicarious conditioning', and that we are influenced

by those people with whom we are most in contact. Bandura (1977) also described four requirements for successful observational learning to take place. These include the ability to pay attention, the ability to remember or 'retain' what is observed, the ability to reproduce behaviour and the motivation to perform or act. From the point of view of therapy these requirements are important too, quite simply because they are often absent in emotionally distressed clients (especially those who are in crisis). This does not mean that such clients cannot be helped by behavioural methods, however. What it does imply is that it may take some time for certain clients to respond positively to such an approach.

Other contributions

Joseph Wolpe (1915–1997), a South African psychiatrist, also contributed significantly to the field of behaviour therapy. In 1958 he developed behavioural methods which were effective in relieving a number of psychological problems, including stress, anxiety and irrational fears. 'Systematic desensitisation', a process he pioneered for the treatment of phobias, is now widely used in therapy. In addition to this he developed the technique of 'progressive relaxation training', which is used in conjunction with systematic desensitisation. These behavioural methods will be discussed later in the chapter.

In 1966 Hans J. Eysenck (1916–1997), a psychologist who worked at the Maudsley Hospital in London, produced a study of the effectiveness of psychoanalysis as a treatment for psychological problems. He compared people who were receiving this treatment with others who had similar problems but received no treatment at all. The results of this study are interesting, and suggest that psychoanalysis achieved very little. In fact, those people receiving no treatment did just as well. The effect of this research was that more attention was focussed on the worked of clinical psychologists and the behavioural work they were doing to help people with emotional problems. Behaviour therapy as a method of treatment was certainly enhanced by Eysenck's intervention.

Behaviour therapy and its view of the person

The behavioural tradition in therapy has been effective in shifting attention away from the intensely introspective approach to clients. The Freudian approach, especially, was emphatic in the belief that unconscious forces and unseen impulses were at the root of most human problems. In order to deal with these problems it was necessary to engage in a series of verbal transactions between client and therapist, which would shed light on these hidden areas of personality.

In contrast to this, the behavioural approach encourages us to focus directly on the client's undesirable behaviour, and to make them the target of various methods which will stimulate relearning and healthy behavioural change. According to the behavioural approach, it is simply not enough to talk about problems, for clients need to 'learn' their way out of them too. The rationale behind such a view is that maladaptive and neurotic problems which have been learned can, according to the same principles of acquisition, be unlearned. The counsellor or therapist is concerned with a person's visible and observable behaviour as well as with the environmental context in which behaviour takes place. Details of the past are important only insofar as they relate to present behaviour, and aspects of the client's emotional life, though certainly acknowledged, are not especially highlighted. The term 'counter-conditioning' is sometimes used to describe the processes and techniques which are central to behaviour therapy.

The therapeutic relationship

In common with all other models of counselling, the behavioural approach places some emphasis on the quality of the client/counsellor relationship. However, since behaviourists have always valued their scientific credentials and the substantial body of research which underpins the approach, attitudes of objectivity in relation to clients have traditionally been the norm. There has been some change in these attitudes in recent years and the importance of rapport and partnership within the therapeutic relationship is now recognised. Richards and McDonald (1990) refer to this 'joint approach' which they see as necessary, especially in the early stages of counselling. In relation to handling strong emotions expressed by clients, they also stress the value of using 'empathic statements' which will convey the counsellor's attitudes of acceptance and understanding. Empathy, therefore, has some place in behavioural counselling, but is not especially highlighted nor deliberately fostered.

Clients are encouraged to become active participants in their own therapy, and indeed a fundamental goal of the behavioural approach is to encourage a sense of personal control in clients. Clear communication between counsellor and client is valued, and this is especially relevant in relation to specific problem behaviour which needs to be changed and the goals which the client wishes to achieve. Behavioural counsellors use all the skills described in the first part of this book, along with attitudes of respect and acceptance towards the people the help. They are also directive in formulating and maintaining individual programmes of therapy for clients.

Focus of therapy

In behavioural counselling there is strict adherence to principles and procedures, which have been scientifically tested for their effectiveness in

relation to specific problems. Techniques and methods used are adapted to meet the individual needs of clients, although there is a definite educational bias within the approach. A basic aim of counselling is to enable clients to exercise more control over their own behaviour and the environment. Another aim is, quite simply, to help clients reduce the distress, anxiety and inconvenience central to most behavioural problems.

Groups

Behavioural counselling is often conducted in groups, and indeed this forum is highly successful for therapy since many clients experience problems in their social and family relationships. The group becomes a source of support and feedback for clients, and provides valuable training opportunities for overcoming limited skills and changing problem behaviour in a safe environment.

The initial assessment

The initial assessment of the client's problems should be accurate and comprehensive so that an individual action plan can be devised. In order to do this well, the counsellor needs to be skilled in gathering and collating information, especially with anxious or emotionally upset clients. The client's problems should be identified early on, and these should also be set in the context in which they occur. In addition, the client's physical and emotional responses in these situations need to be identified. The following considerations are also important:

- the nature of the problem
- the client's first experience of the problem and where it occurred
- the sequence of events following the experience
- factors which may have prompted the problem
- the client's actions and thoughts in the problem situation described
- how frequently the problem behaviour occurs
- the duration and intensity of the problem behaviour
- any factors which worsen or relive the problem
- effects of the problem on aspects of everyday life, including work, social life and family
- identification of other people associated with the problem.

EXERCISE

Problem assessment

Working individually, think of a personal problem you have had in the past. Describe your experiences in relation to the problem, using the list of considerations just described. Start by stating the nature of the problem, and then work through the other points above. Afterwards, discuss your findings in groups of three to four, paying special attention to any aspect of your experience not included in the list.

Observation of clients

Apart from the information clients convey verbally at the initial assessment, they also provide non-verbal clues about the nature and severity of their problems. Changes in voice tone and general demeanour will, for example, say much about the level of distress a specific problem causes to a client. It is also possible to see just how socially inept or otherwise a client may be and as Nelson-Jones (1996) indicates, interview assessment affords an opportunity to identify the factors which individual clients find personally reinforcing. These factors include praise, attention and encouragement, and they can prove useful in helping clients to change problem behaviour.

Setting and implementing goals

The setting of specific goals follows the initial assessment or behavioural analysis. These goals need to be considered jointly by both client and counsellor, and the client in particular should be fully aware of the purpose of these goals. Commitment to objectives is important too, and one way of achieving this is to establish a contract between counsellor and client in which desired changes are clearly stated. It is essential that clients experience some measure of control in the setting and implementation of goals, and to this end ongoing communication and negotiation between client and counsellor is the norm. When goals have been discussed and correctly defined, an action plan is set up and a definite decision is made by both client and counsellor to work together – unless it has become obvious that a different form of therapy would be in the client's best interests. There are some clients who do not respond well to a behavioural approach, and these and other limitations will be discussed later in the chapter. In behavioural therapy assessment continues throughout all the sessions. This is important in order to ensure that goals are either being met or altered in the light of changing situations.

Behavioural methods and procedures

The methods and procedures used in behavioural therapy are all designed to meet the needs of individual clients. There is no rigid set of techniques and the view of helpers in this field is that since each client is unique, all helping procedures must reflect and address this. However, behaviourism does have within its repertoire a wide range of methods which can be used with clients, and counsellors' creativity and innovation are valued as well. The following is a summary of established behavioural techniques, which are frequently used successfully in therapy:

- relaxation training
- systematic desensitisation
- client self-monitoring
- practising and planning behaviour

- assertiveness training
- social skills training
- reinforcement methods
- modelling
- focus on physical exercise and nutrition
- imagery and visualisation.

Relaxation training

Anxiety and stress are common problems for many clients who seek behavioural counselling. In view of this, relaxation training is a central focus of the approach and is used extensively for a variety of problems. Anxiety, which is quite different from fear, affects people on three levels – psychological, physiological and behavioural. Whereas fear tends to have a definite external focus, anxiety is usually internal and often unrelated to a specific identifiable cause. When clients talk about anxiety they sometimes describe it as a 'vague feeling of losing control' or as a 'sense that something awful will happen'. In order to combat the cycle of anxiety, it is useful to start by explaining its effect to clients. When this is done, relaxation techniques make much more sense, and clients are likely to engage in this approach with greater commitment.

Anxiety tends to increase the heart and breathing rates and may cause a variety of other symptoms including muscle tension, irritability, sleep problems and difficulty in concentrating. Counsellors can show clients how to reduce these effects by teaching concentration on the following key areas:

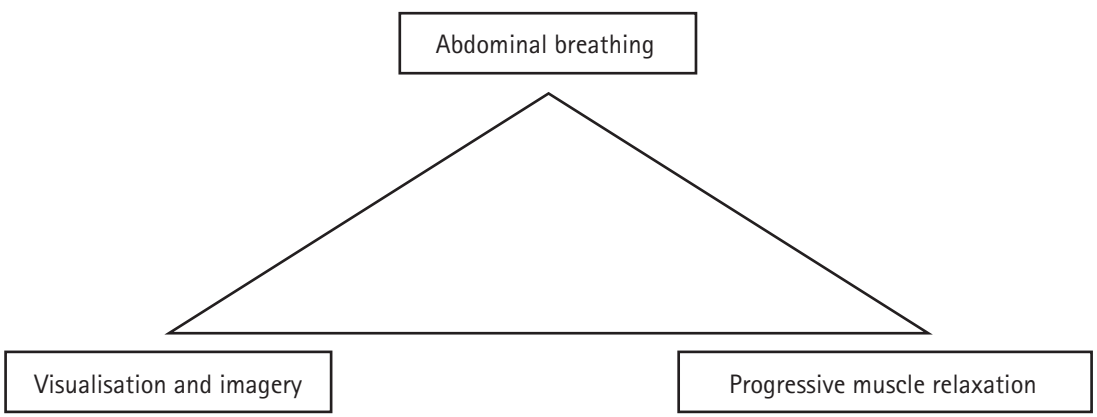

Figure 8.2 Aids to relaxation

Many anxious people tend to breathe in a shallow fashion from the chest, and clients can be taught to change this pattern so that deeper abdominal breathing is learned. This has the effect of increasing oxygen supply to the brain and muscles which, in turn, helps to improve concentration, promote a state of calmness along with deeper feelings of connectedness

EXERCISE

Relaxation

Sit quietly in a chair until you feel still and comfortable. Beginning with your feet, allow all the muscles of your body to relax. Place your hand on your abdomen and breathe in slowly and deeply through your nose. You should feel your abdomen extend as you do this. Now breathe out slowly through your mouth, noting how your abdomen returns to its usual shape. Repeat the breathing exercise for about five minutes, then sit still again and experience your relaxed state. A slight variation of the exercise is to repeat a chosen word or phrase each time you breathe out.

Note: This simple exercise forms the basis of most relaxation techniques. To test its effectiveness, you could ask someone to take your pulse before and after the exercise. Your pulse rate should be slower afterwards, which indicates a more relaxed state.

between mind and body. These feelings are exactly the opposite of those experienced in anxiety and stress, and when deep breathing is accompanied by progressive relaxation of body muscles, and visualisation of a peaceful scene, reduction of general anxiety is bound to follow.

There are numerous instruction manuals and tapes for teaching these techniques, and anyone interested in helping clients in this approach should become familiar with them. Clients can be taught to set aside time each day for relaxation, and this is especially beneficial for those people who suffer from stress-related conditions such as tension headaches, poor sleep patterns and high blood pressure.

Systematic desensitisation

Systematic desensitisation is a technique devised by Joseph Wolpe, whose research was outlined earlier in this chapter. It is used in behavioural counselling as a means of helping clients deal with irrational fears and phobias. Wolpe believed that it is impossible for a person to be anxious and relaxed at the same time, since these two states are mutually exclusive. He also believed that anxiety responses are learned or conditioned, and that it is possible to eliminate these responses if the anxious individual is helped to relax in the face of the anxiety-producing stimulus. The person is, therefore, 'systematically desensitised' to the fearful object or situation through a process of exposure to it, while in a relaxed state. Progressive muscle relaxation methods and deep breathing are integral to this technique, and clients are taught how to reduce anxiety in this way before they confront their fear. Constructing an appropriate 'hierarchy' is another important feature of systematic desensitisation, and involves outlining a series of situations or scenes relating to the phobia. Each scene in the hierarchy is ranked from mildly anxiety-provoking to extremely anxiety-provoking.

CASE STUDY Constructing a hierarchy

The following is an example of a hierarchy which was used to help a client called Isobel, aged twenty, who had a phobia about eating in front of strangers. Isobel's phobia was embarrassing and inconvenient because it meant that she refused to socialise on many occasions. She also found herself increasingly isolated at work, and decided to seek help when she no longer felt able to accompany her friends to the lunch canteen. The counsellor taught Isobel the relaxation procedure and breathing methods already discussed, and then helped her to design and work though the following hierarchy, which she was encouraged to practise on a regular basis:

Visualise:

- asking a close friend to accompany you on a visit to a restaurant
- phoning a restaurant to make a reservation
- getting dressed for your evening out
- doing your hair and putting on make up
- opening the door to greet your friend
- walking to the restaurant a short distance away
- meeting people along the way
- passing other cafés and restaurants as you walk along
- arriving at the door of the restaurant
- speaking to the waiter about your reservation
- walking to the table with your friend and the waiter
- looking at the menu and discussing it with your friend
- placing an order with the waiter
- looking at your food when it arrives
- picking up the knife and fork and starting to eat
- tasting the food and enjoying it
- looking around at the other diners
- noting that other people are enjoying themselves
- becoming aware that other people occasionally glance at your table
- continuing your meal and the conversation with your friend.

Designing the hierarchy

Clients need to give a detailed history of the phobia, with special emphasis on those aspects of it which cause the most anxiety. What made this client most anxious was the thought of being observed while eating. For this reason, observation was presented towards the end of the hierarchy which meant that Isobel could work very gradually towards it.

Real-life desensitisation

It should be emphasised that this exercise was based on imagery, and that later on the client and counsellor constructed a hierarchy for 'real-life' exposure. Real-life desensitisation is perhaps the most effective method of dealing with phobias, and is quite often used following a period of visual or imagery desensitisation. 'Exposure therapy' is another term used to describe this form of treatment (Bourne, 1995), and it is especially effective for phobias which include a 'social' element, as Isobel's did. However, real-life exposure does take time, because the introduction of anxiety-provoking stimuli needs to be very gradual. Not all clients with phobias are willing to undertake real-life exposure, since the process causes some degree of initial discomfort at least. It also needs to be practised over a period of time, on a regular basis and in spite of probable setbacks.

Client self-monitoring

In behaviour therapy clients are sometimes asked to maintain records of their behaviour, with particular references to those aspects of it which are problematic along with any attendant conditions. A self-record may take the form of a daily diary, and one of the benefits of this kind of self-monitoring is that clients often react to their own observations by reducing the frequency of their own problem behaviour (Phares, 1988). People who smoke, for example, may not realise quite how many cigarettes they get through in a day, until they see the evidence on record. Client self-monitoring does have great therapeutic potential, though clients need to be well motivated to pursue it.

Assertiveness training

Assertiveness training is widely used in behaviour therapy and counselling. Clients often experience difficulties in several key areas. These include:

- expressing their feelings
- asking for what they need or want
- saying no to requests from others.

The most important aspect of assertiveness training is in helping clients differentiate between 'submissive', 'aggressive' and 'assertive' styles of communication. When people are submissive they tend to ignore their own rights and needs, and this can result in feelings of depression and anger which are never really expressed. Aggressive people may be bullying and demanding, characteristics which inevitably alienate others. On the other hand, assertive behaviour involves direct person-to-person communication, without manipulation, hostility or self-abnegation. Assertiveness training is often conducted in a group setting, and non-assertive clients who express an interest are sometimes referred to them so that they can increase their self-awareness and confidence generally.

CASE STUDY Stacy

Stacy, who was twenty-seven and unemployed, attended an assertiveness training course. During the first session the group facilitator asked each person to identify their usual style of relating to others. Stacy said straight away that she usually found herself helping other people. She found it difficult to refuse once someone asked her for help. When she did help, she often felt resentful afterwards. In spite of her resentment, however, she lacked the courage to refuse friends or family when they made their requests. During the training sessions, the group facilitator helped Stacy to see that it wasn't courage but skill which she lacked in dealing effectively with repeated requests.

The course provided Stacy and the other group participants with a set of skills which would help them develop assertiveness. They were taught to differentiate between assertive, aggressive, passive and manipulative behaviour. They were also given practice in dealing with conflict, expressing feelings appropriately, dealing with awkward situations and saying 'no' confidently. The skills which Stacy learned on the course helped her in her next job interview. She did not allow herself to become overawed by the interviewers; she expressed herself confidently and clearly, and was offered the job. In addition, Stacy stopped giving in automatically to family and friends when they asked for favours.

Social skills training

Clients also frequently experience difficulties in social situations, and this is another area in which behavioural counselling offers some support to clients. In many ways there is an overlap with assertiveness training here which incorporates the social skills dimension, but it is also possible for counsellors to offer some individual skills training to those clients who request help in this way. 'Practising and planning behaviour' is one aspect of social skills training, and this may take the form of role play of a specific situation seen as problematic or daunting by the client. The practice of interview techniques is one example of this kind of approach, and in behavioural counselling such methods and techniques are commonly used. In social skills training there is an emphasis on setting achievable goals so that maximum positive reinforcement is obtained for new behaviours early on.

Modelling

Observational learning or modelling is sometimes used to help clients acquire new forms of behaviour. The emphasis in this technique is on showing clients that certain behaviours can be undertaken (in this case by the counsellor) in a calm and non-threatening way. This is especially

effective when used in conjunction with systematic desensitisation, especially when the counsellor 'models' the behaviour which the client associates with anxiety and stress. Videotapes are sometimes used as part of a modelling programme, and 'participation modelling' is another variant.

This technique refers to a process in which both client and counsellor participate. A counsellor might, for example, model attitudes of composure and calm while walking into a restaurant. Later on, the client can practise this behaviour in the company of the counsellor.

Reinforcement

Understanding of reinforcement principles is essential in behavioural counselling. Certain problems, such as persistent cleansing rituals or hypochondria, require environmental reinforcement to make them continue. As Avery (1996) points out, people who look for dirt will always find it, and those who seek reassurances about their health are likely to get it from friends and family. In these two problem situations the environmental reinforcement can be broken, in the first instance, by helping the client to interrupt the cleansing ritual and substituting something else. In the second instance they can enlist the help of the client's friends and persuade them to 'withhold reassurance' (Avery, 1996).

Positive reinforcement

Positive reinforcement is based on the work of Skinner and his theory of operant conditioning. The behavioural approach to counselling places considerable emphasis on the practice of systematically reinforcing a client's desired behaviour, while at the same time ignoring any problematic behaviour. If positive reinforcement is continued over a period of time, then maladaptive behaviour should become extinct. Clients can also be encouraged to identify and use their own reinforcers. This kind of self-reinforcement will obviously vary for different clients, but often activities which are calming or relaxing are effective in most cases. One client, a woman in her mid-forties, suffered from obsessive compulsive disorder (OCD), which in her case took the form of persistent tidying and checking. In conversation with her counsellor she mentioned that she used to love playing the piano, and later on she returned to this interest and used it as a calming self-reinforcer which helped her to break the tidying and checking compulsion.

Physical exercise and nutrition

In recent years a great deal of attention has been given to the importance of exercise and diet in the maintenance of individual fitness. Although the link between physical health and these two factors has always been accepted, the significance of diet and exercise in relation to

psychological health was traditionally less emphasised. This situation is currently changing, and nutritional experts, including Patrick Holford, have conducted research into the effects of diet on emotional and psychological health. In his book *Optimum Nutrition for the Mind* (2003), he describes the importance of a well-balanced diet for physical and psychological health. Clients often eat less or more while under stress and it is a good idea to address this aspect of their behaviour with them.

CASE STUDY Diet and exercise

One client, called Jeanette, described the depression and feelings of tiredness she experienced at work. During counselling she revealed that she regularly skipped breakfast and then snacked on convenience food for the rest of the day. She also worried about her weight and took no exercise because she felt she was too busy to do so. Through a process of self-monitoring Jeanette was able to chart her mood swings in diary form, and afterwards to see that her depression was certainly exacerbated by dietary neglect and inertia. In behavioural counselling clients should be encouraged to address issues of diet and exercise so that the behavioural aspects of both are highlighted. It is possible to 'unlearn' patterns of behaviour which contribute to feelings of depression, stress and tiredness, and it is also possible for clients to 're-learn' healthier habits, though they do need encouragement, feedback and support in order to do this.

Clients who benefit from this approach

Clients with a wide range of problems respond well to behavioural counselling. Several of these problems – phobias, certain aspects of depression and lack of assertiveness for example – have been highlighted in this chapter. However, any psychological difficulty manifest through observable behaviour is likely to respond well to this approach. Clients who suffer from obsessions and compulsions often find that behavioural counselling enables them to deal more effectively with their problems. People with sexual difficulties often seek help through behavioural therapy and counselling, and clients with speech problems such as stammering or an inability to speak publicly can also be helped. Behavioural therapy is widely used in stress management and assertiveness training, and its principles are applicable in the management of childhood behaviour problems, and very often care of the elderly. Behaviour therapy is widely available, both within the NHS and privately. However, there is an increasing emphasis on the role of thinking in determining behaviour, which means that clients seeking help are now more likely to be offered cognitive behaviour therapy than the older form of behaviour therapy.

Some limitations

We have noted that the behavioural approach is especially helpful in dealing with problems manifest through overt behaviour. This strength is, in fact, also its weakness, since the problems often stem from deeper and hidden origins which need to be addressed in the long term. A client who has a phobia about the dark, for example, may well respond to a behavioural approach in counselling, but unless the hidden insecurity which prompted the phobia in the first place is identified, lasting cure of the problem is unlikely. On the other hand, even temporary alleviation of the phobia might give the client sufficient inclination to look at less obvious issues, so that overall real progress is made and insight gained.

Clients need to be fully committed, especially at the beginning of counselling when stress levels are high and the gratification gained obtained through problem behaviour is still very attractive. Counsellors who work from a strictly behavioural perspective are at risk of adopting a mechanistic or over-simplified view of clients. This is because a basic principle of approach is that people react in an automatic way to stimuli – a view which leaves little room for the influence of thinking, or cognition in determining behaviour. However, the balance has now been redressed through the influence of cognitive therapy, which we shall consider in the next section.

The cognitive emphasis

As the name suggests, cognitive therapy is concerned with the thinking and reasoning aspects of a person's experience. We have seen that behaviour therapy evolved from the theories of learning first formulated by Pavlov, Watson, Thorndike, Skinner, Wolpe and Eysenck, and from the experiments of Bandura and other psychologists interested in the effects of observation on the individual's learning experience. The behavioural approach, widely used in the 1950s, emphasised the importance of visible behaviour and its environmental context. However, this emphasis tended to ignore the thinking and feeling aspects of human behaviour and it was not until several psychologists, including Aaron Beck and Albert Ellis, began to focus on the thoughts and beliefs of disturbed or anxious clients, that the cognitive dimension came into being.

The work of these theorists highlights the way in which anxious and depressed clients contribute to their own problems through faulty or destructive thought processes and preoccupations. In this section we shall look in some detail at the work of Albert Ellis, whose Rational Emotive Behaviour Therapy model is one of the most established and widely used cognitive behavioural approaches.

Rational emotive behaviour therapy

Albert Ellis (1913–2007)

Albert Ellis was responsible for pioneering cognitive behaviour therapy (CBT) at the beginning of 1955, and since then his own individual approach, now called Rational Emotive Behaviour Therapy, has become one of the most popular cognitive models. Ellis himself claimed that Rational Emotive Behaviour Therapy was the 'original' cognitive behaviour approach to psychological problems (Ellis, 1995).

Ellis, who was born in Pittsburg, Pennsylvania, was President of the Albert Ellis Institute in New York. Up until his nineties, and despite numerous health problems, he conducted regular workshops in Rational Emotive Behaviour Therapy at the Institute. His background training included studies in accounting, clinical psychology, writing, family and marriage counselling and psychoanalysis. Ellis trained in classical Freudian analysis, although he never wholly subscribed to many of the basic principles of that discipline. In particular, he questioned the efficacy of free association and dream interpretation as techniques in therapy, and he doubted the overall efficiency of psychoanalysis as a form of helping (Ellis, 1962). Classical psychoanalysis is an in-depth and time consuming form of therapy not suited (or available) to many clients, and Ellis was concerned to establish a more egalitarian and pragmatic approach which would address the needs of a wider range of people who sought help.

Albert Ellis held many posts throughout his career, including Consultant in Clinical Psychology to the New York Board of Education and Vice President of the American Academy of Psychotherapists. He also wrote numerous books and articles, and served as consulting or associate editor of many professional journals.

Development of the approach

During the 1950s Ellis became interested in behavioural learning theory. He noted that psychoanalysis and learning theory have a great deal in common, since both emphasise the importance of conditioning in early life. However, he concluded that action, as well as insight, is necessary if people are to address the difficulties which stem from childhood and the early conditioning which determines so many problematic responses in adult life. In addition, Ellis identified the central place of negative thinking in the perpetuation of emotional disturbance and he was especially interested in the kind of negative thinking which reinforces early disturbing and traumatic experiences. Clients, he believed, often cling to outdated feelings of depression, anger and guilt which impede psychological growth and are, in any case, no longer applicable to the present situation. Outdated or negative thinking is often the direct result

of information which has been conveyed to clients at an early stage, by parents or other important people at that time.

In Ellis' view, the language is the key to the perpetuation of emotional problems since it is through the use of language or internal dialogue that clients reinforce their fears and anxieties stemming from early life. To compound the problem even further, people frequently denigrate themselves and their efforts, demand perfection from themselves and others and exhibit what Ellis (1995) refered to as 'low frustration tolerance' towards others and the environment in general.

Other influences

The importance of both language and thinking is stressed throughout Ellis' writing. References to philosophy and literature are also frequent, and indeed these two subjects have informed and helped define many aspects of his work. Ellis was especially interested in the Stoic philosophers, including Epictetus, who believed that people become disturbed, not by events themselves but by personal interpretations of those events.

Development of the title

The original title of Ellis' approach was 'Rational Psychotherapy', but it soon became apparent to him that such a description did not adequately address every aspect of the work he was doing. He also wished to differentiate between his own model and other, purely cognitive approaches which had become popular in the 1950s. In 1959, two years after he abandoned psychoanalysis, he founded the Institute for Rational Emotive Therapy, now the Albert Ellis Institute. Ellis described his model as 'Rational Emotive Therapy' in order to highlight the emotional focus of his work. In 1993 this was again changed to rational emotive behaviour therapy, a title which stresses the significance of all three components – cognitive, emotional and behavioural – of human experience.

The theory of rational emotive behaviour therapy

Ellis believed that emotional and neurotic problems are generated from three important sources. These include thinking, emotional and behavioural sources, but he placed special emphasis on the significance of 'cognition' or thinking in the perpetuation of psychological disturbance. Ellis referred to the views of a number of philosophers to support his thesis (Ellis, 1995) and suggested that people are 'largely responsible' for their own disturbed feelings which they either consciously or unconsciously generate. If we accept that this is the case then it follows, according to Ellis, that people have within themselves the resources and willpower necessary to effect lasting and healthy change. Ellis (1995) described the sequence of events which lead to psychological disturbance through the use of an ABC model (see Figure 8.3).

In the first instance, people start with goals in life, and these are usually constructive and positive. What tends to happen, however, is that difficulties (or 'activating events') are encountered at various stages which impede the individual's desire for success and comfort. After this, people construct their own largely negative 'beliefs' or interpretations of these events, and these beliefs lead to certain emotional and behavioural 'consequences.

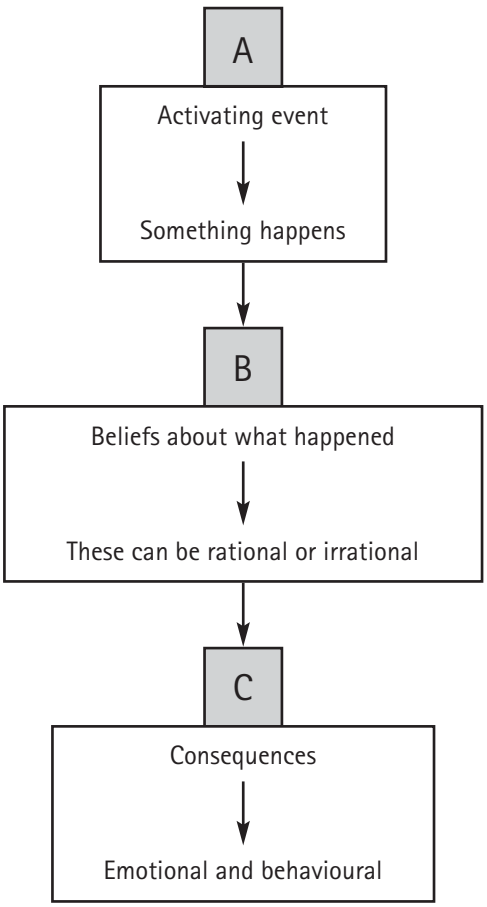

Figure 8.3 The ABC model

CASE STUDY The ABC model

Bill, who was in his fifties, had a very good relationship with his next door neighbour Roy, who was about the same age. Bill applied to his doctor for counselling help because he suffered from increasing depression linked to several significant changes in his life. His parents had died in the previous year, and he had just discovered that his daughter's marriage was breaking up. In addition to his depression, Bill suffered from severe loss of confidence which, he said, had been prompted by his experience of early retirement and by feelings of panic about his age. During counselling Bill talked about an incident with his neighbour which had caused him a great deal of anxiety and had knocked his confidence even further. Roy's eight-year-old grandson had come to stay for a holiday and several days later, Bill's own grandson came to stay with him too. When Bill suggested to his neighbour that they should plan some activities together, Roy responded by saying that while he would be happy to share some time as a group, he would also like to reserve most outings with his grandson and members of his own family. Bill ruminated at length about this response which he took as a personal rejection of himself and the friendship he offered. Afterwards he became even more depressed and withdrawn, and for several weeks avoided his neighbour. The rational emotive therapy model, see Figure 8.4, shows in diagram form this sequence of events.

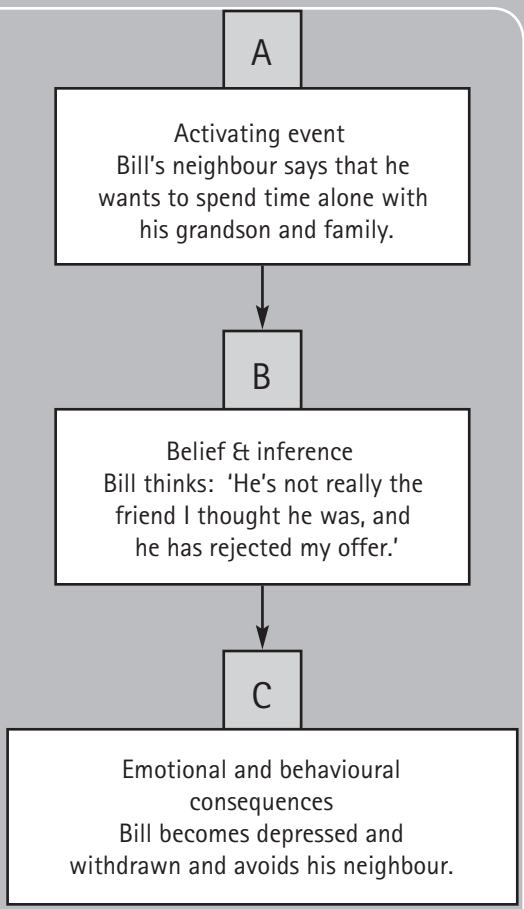

Figure 8.4 Irrational thinking and emotional disturbance

COMMENTARY Ellis' ABC model of personality and emotional disturbance highlights the relationship between thinking and emotion. In Ellis' view (1962) it is not what happens at point A which causes emotional disturbance or distress. People form their own inferences and beliefs at point B, and reinforce them through the use of negative and 'catastrophising' self-talk and rumination. It is this internal soliloquy which then leads to the emotional and behavioural reactions which occur at point C. Bill's action in avoiding his neighbour led to a worsening situation, since after a while Roy stopped making social overtures in the mistaken belief that Bill had lost interest. This had the effect of deepening Bill's depression and general loss of confidence. In counselling he was helped to see how his own thinking had contributed to his problems overall. The counsellor explained the ABC model of rational emotive behaviour therapy to Bill. It should be added, however, that there were other factors in this client's life which contributed to his depression, and these were also addressed in counselling.

The following example, Figure 8.5, shows how Bill might have chosen to respond to the activating event described.

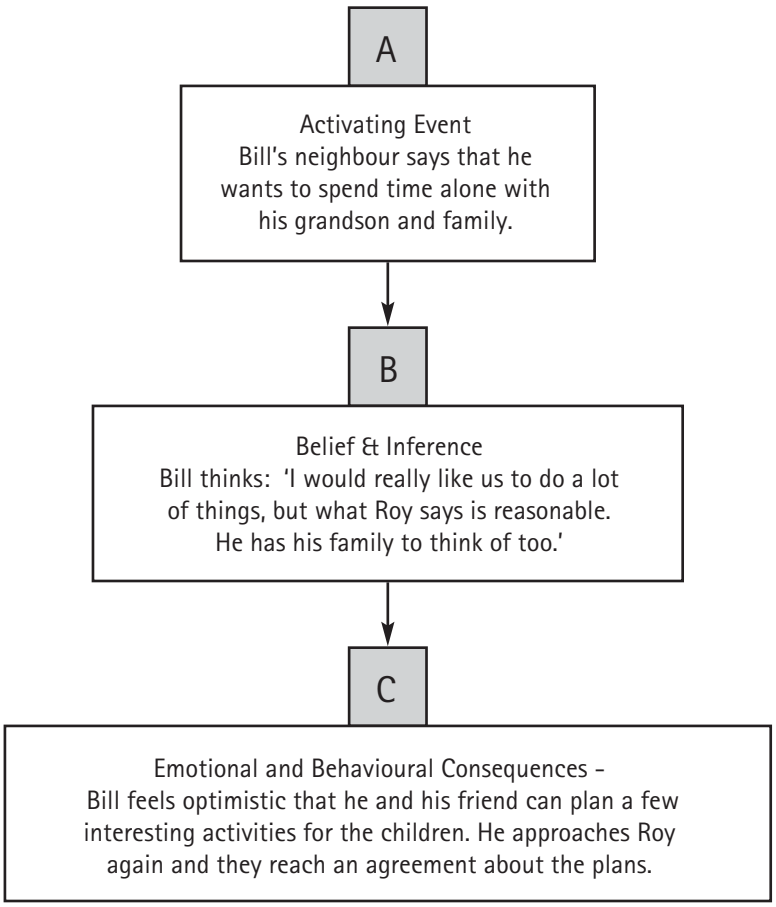

Figure 8.5 Changing irrational beliefs

Rational and irrational thinking

Ellis (1995) took the view that people have a basic tendency to be irrational as well as rational in their thinking. Irrational thinking is seen as a fundamental cause of psychological disturbance. It is developed early in life and is due, in part, to biological tendencies, but it is also the result of social learning and the emotional investment we all have in our own particular beliefs. Rational emotive behaviour therapy aims to help clients develop more rational, less punitive, ways of thinking, and this means encouraging them to consider the ways in which their irrational thinking of the past has contributed to numerous problems. Clients are also encouraged to work towards long-, rather than short-term change, so that the ordinary (and less ordinary) difficulties of life are dealt with more effectively as time goes on.

Some irrational beliefs

According to Ellis (1962) most people subscribe to a number of irrational or illogical beliefs which lead to many of the problems experienced by clients. These beliefs, which are seldom questioned by anyone, tend to be passed from one generation to another so that they become accepted wisdom. Ellis referred to these beliefs as 'superstitions and prejudices' and he went on to say that they can, in his opinion, only be changed through a basic 'ideational or philosophical' shift in modern outlook. The following are some of the irrational beliefs which he described:

- I should always be loved and approved of by everyone.
- In order to be a worthwhile person, I need to be good at everything.
- Bad people, including myself, should be severely punished.
- If things are not the way I want them to be, it's a disaster.
- I have no real control over my problems, which are caused by external factors.
- I need to keep on reminding myself of the awful things that may happen.
- It's easier to avoid than to face problems and responsibilities.
- I always need someone stronger to take care of me.
- I can't change my behaviour because of my awful past.
- I should always become emotionally engaged in other people's problems.

Adapted from Ellis (1962)

EXERCISE

Irrational beliefs

Working with a partner, look at the above list of irrational beliefs and say how many of them you subscribe to, or may have subscribed to at certain times of your life. Discuss these with your partner, paying special attention to any beliefs you have in common. Consider the origins of such beliefs and say how you think you may have acquired your own.

Shoulds and musts

Throughout his writing on the subject of rational emotive behaviour therapy, Ellis often referred to the words 'should and 'must' which, he said, are frequently used by clients who seek to impose 'absolutist' demands on themselves and others. People may, for example, express the view that they 'must' be good at certain things, or that other people 'must' always be nice to them. If these 'musts' are not realised, life is seen as intolerable, awful or not worth living. These misleading and 'disturbance producing' shoulds and musts are irrational according to Ellis (1995), and in rational emotive behaviour therapy they are regarded as primary causes of emotional problems. Ellis also used the terms 'catastrophise' and 'awfulise' to describe these forms of irrational thinking which tend to cause disturbed or neurotic behaviour. In addition, Ellis believed that once people accept their own or others'

irrational beliefs, they are likely to produce what he calls 'secondary disturbances'. Thus people often become very anxious abut their anxiety, depressed about their depression, or self-loathing about their anger towards others (Ellis, 1995).

Helping clients to change

In rational emotive behaviour therapy clients are taught the ABC model at an early stage. Clients are also encouraged to look at the 'activating event' and the 'emotional disturbance' they have experienced. Afterwards, attention is directed to the 'beliefs' and inferences which have created such a powerful influence in the production of emotional disturbance. It is possible to teach this model effectively and quickly and most clients, apart from those who are seriously ill or confused, are able to grasp it. Clients are also encouraged to identify and dispute their 'musts' and any other irrational beliefs they entertain.

This is a highly active and directive approach which incorporates elements of teaching, persuasion, debate and even humour within its repertoire. Ellis was, in fact, notable among psychotherapists and counsellors for his support of humour as a therapeutic aid. It is not something we tend to associate with therapists who, as a group, have always been somewhat suspicious of levity and its effects on the serious business of relating to clients. There are various reasons for this reluctance to laugh when things are ludicrous or funny, and it has to be said that humour is indeed often inappropriate in the therapeutic context. However, as Strean (1994) indicates, Freud himself admired humour and freely appreciated it in his friends and in his patients. Ellis, too, appreciated it, and he recommended the use of humour as a way of helping clients to 'interrupt' their own seriousness and to separate themselves from stuffy, outmoded and 'dysfunctional' beliefs (Ellis, 1995). It goes without saying, however, that humour should never be used against clients in therapy. It also needs to be sensitively timed and appropriate to the situation. The following is an example of the way humour was used with one client who had a compulsion to check, at very frequent intervals, all the cups in the kitchen cupboard.

CLIENT: What we talked about last time did work quite well. Instead of checking the cups when I got home from shopping, I went out into the garden instead and did some work there. I felt a lot better about doing that. I think it's getting better, but I still feel like counting something.

COUNSELLOR: The saucepans and cutlery maybe?

CLIENT: Oh, God, no [laughs]. Well I am beginning to look more closely at the way I think about this checking, and I can see how I have actually been thinking the worst . . . that if

I don't count the cups, everything will go wrong and I'll be out of control. I actually can laugh at myself now and I think that's real progress.

Homework and other tasks

Clients may be given homework tasks to do, and they are frequently asked to read self-help books on the subject of rational emotive behaviour therapy. Homework may include self-monitoring and recording of negative thoughts and self-sabotaging beliefs, as well as exercises in critical thinking and questioning. Written work is sometimes included in homework exercises, and this might take the form of writing down and disputing personal beliefs which may have caused problems in the past. Imagery is another technique used in this approach, and clients are sometimes asked to 'imagine' themselves responding in positive ways to situations which have been problematic for them in the past.

Role play, which is used extensively in assertiveness training and behaviour therapy, is incorporated into the Ellis model. A client could, for example, role play some feared or threatening future event such as public speaking, a job interview or an appointment to ask for a change of conditions at work. 'Modelling' is also used, but in this approach its application is not restricted to counselling sessions. It may be extended to models of positive behaviour which clients may have observed in others. Many clients are familiar with favourite characters in literature who display the kinds of personal qualities they would like to develop.

Ellis (1995) referred to the technique of 'cognitive distraction' as a means of helping clients deal with anxiety and depression. In simple terms, this means encouraging clients to learn relaxation procedures, yoga or meditation, but it also means teaching them how to dispute the irrational beliefs which cause problems for them. 'Semantic correction' is another interesting Rational Emotive Behaviour Therapy technique which is used with clients who over-generalise or make sweeping statements. The following is an example:

CLIENT:	People always let me down, always. Then I get depressed and fed up.
COUNSELLOR:	Absolutely always let you down?
CLIENT:	Well no, but quite often.
COUNSELLOR:	Try changing what you first said around a bit.
CLIENT:	In what way?
COUNSELLOR:	Instead of the statement you made, change it to this: I allow myself to become depressed and fed up when other people let me down.
CLIENT:	Like the ABC we discussed? Yes, but it takes time to change things around like that.
COUNSELLOR:	That's why all the practice is important.

Dealing with shame

In Ellis' view feelings of shame, guilt or inadequacy are responsible for many of the problems which prompt people to seek help in therapy (Ellis, 1962). In order to help clients deal with these feelings he devised what are referred to as 'shame-attacking' exercises. People who are fearful of exposing personal weakness, or those who are inhibited about expressing themselves, are encouraged to take risks and engage in some form of activity which will prove to them that their fears are exaggerated. A client might, for example, be asked to become more gregarious socially, either in dress, behaviour or manner. The purpose behind this approach is to show clients that they need not feel ashamed, nor will anything awful happen to them if they take more risks.

Contracts and commitment

Rational Emotive Behaviour can be used as a brief therapy, but it is also suited to longer term counselling when necessary. A primary focus of the model is to help clients understand the connection between thinking and emotional disturbance, which means they also need to understand the purpose of the exercises which they are asked to do. Commitment to completion of assignments is important too, and any tasks which clients do should be discussed in later counselling sessions. The behavioural focus in rational emotive behaviour therapy requires that clients receive 'positive reinforcement' for any progress they make. A working contract is always established at the beginning of therapy, the terms of which are detailed and specific.

The therapeutic relationship

We have seen that rational emotive behaviour therapy is an active, directive and teaching approach to counselling. It is these characteristics which set it apart from many of the other models we have discussed in this book. However, the actual relationship between counsellor and client is just as important in this approach as it is in any other. Dryden (1999) suggests that flexibility is an essential attitude on the counsellor's part. What works with one client might not necessarily work for another, so counsellors need to be open to the needs of individual clients. The counselling relationship is an egalitarian one, although equality may not be obvious at the beginning of therapy when clients are disadvantaged because of the problems which preoccupy them. Once therapy is established however, counsellors are frequently willing to disclose information which is seen as helpful or encouraging for clients. This might include details of problems similar to those experienced by the client.

The Rogerian concept of empathy is problematic in rational emotive behaviour therapy, where attitudes of detachment and understanding are valued highly. Counsellors need to be separate from the irrational

views which clients express, and this means refusing to collude with or support these views when they are articulated. The concept of 'transference' is also viewed differently in this approach. Indeed, the idea that the counsellor should encourage a client's irrational dependence is anathema, and contrary to all the basic principles of rational emotive behaviour therapy. 'Debate' has a central place in the model, and is meant to encourage openness and honesty between client and counsellor. In a document published on the internet, Ellis (2005) highlighted the point that REBT therapists give all clients unconditional positive regard, no matter what these clients have done or what mistakes they have made. He added that therapists also teach their clients to accept themselves totally, in spite of the shame and guilt that they may experience because of their failings. Unconditional positive regard is, as we have seen in Chapter 5, a Rogerian concept, but it is one that Ellis was concerned to emphasise in his own approach to clients.

We have seen that humour is frequently used, and this goes along with an atmosphere of informality meant to encourage creative and less rigid attitudes in clients generally. On the other hand, there are clients who prefer a more formal approach and these wishes are centrally accommodated in the model. 'Logic' and 'persuasion' are valuable skills which are also used extensively in rational emotive behaviour therapy.

Group work

Rational emotive behaviour therapy is often conducted in a group setting. Although resistant to the idea of group therapy initially, Ellis later came to regard it as an effective medium for helping clients. All the advantages of group work apply to rational emotive behaviour therapy, but there is an added bonus in the sense that more people are available to dispute their own and other people's irrational beliefs and statements. Therapy can take place in single-sex or mixed groups, large groups or small groups, although Ellis himself favoured a large group setting which, he suggested, tend to be more 'lively' with more interesting material available for discussion (Ellis, 1962).

Another significant aspect of rational emotive behaviour group work is that all the members are taught the principles of the approach. This means that individual participants can (with the guidance of the group leader) take turns in the role of facilitator or therapist, an experience which is empowering for them. Some members of the group may also attend individual therapy sessions, and when this is the case the group can supply the extra support often needed to consolidate the progress made in the individual setting.

Clients who benefit from this approach

Clients who lack assertiveness, or those who experience problems in relation to negative thinking and depression, are likely to benefit from

a rational emotive behaviour approach in either an individual therapy or group work setting. Those who need specific interventions, such as family or marital therapy, may also be helped by therapists who are trained to use the model. Rational emotive behaviour therapy is accessible and fairly easy to understand, which means that the majority of clients (or at least those with the kinds of problems already mentioned) can benefit from it. The principles of the approach can be applied to education and child therapy as well, and this flexibility of application is one of its main assets.

Corey (2007) makes the point that the focus on learning and teaching, which is central to rational emotive behaviour therapy, ensures that many clients regard it in a positive light, and untainted with associations of mental illness. In addition, there are many clients who welcome the stress on action under the direction of the therapist. Tasks like homework and role play may motivate those clients who would normally find it difficult to move into action without some support, initially at least. Putting ideas into action can inspire a real sense of achievement, though clients need to be committed and reinforced for all the gains they make. Rational emotive behaviour therapy can also be viewed as a self-help approach, since it advocates reading, listening to tapes, attendance at lectures and workshops, and generally becoming independent in the search for improvement and change. This is an aspect of the model which helps to give confidence to those clients who use it. Clients are further encouraged to view themselves as capable of making change, regardless of any past traumas they may have suffered.

Some limitations

Clients who wish to conduct an in-depth study of childhood events and attendant traumas are unlikely to seek rational emotive behaviour therapy in order to do so. This is because the approach tends to minimise the past, although this does not imply that Ellis regarded the past as irrelevant in any way. On the contrary Ellis, who trained in Freudian psychoanalysis, was aware of the influence of past events, but he came to believe that little progress could be make through dwelling on them (Ellis, 1962).

To Ellis' own surprise, the rational emotive behaviour methods which he devised produced quicker and more lasting results than those gained through deep analysis. However, critics of rational emotive behaviour therapy stress the point that fast methods can produce fast results which may, in the end, be fairly transitory. The active, directive and action-based nature of the approach may not appeal to some clients, and indeed there are probably a few who might feel quite threatened by it. If certain irrational beliefs are too vigorously disputed early in therapy, clients may vote with their feet and leave. On the other hand, as Weinrach (1995) has suggested, this kind of situation can be avoided through the use

of 'appropriate empathy' and the direction of attention to the client's subjective experience of the problem.

Solution focused brief therapy

We have seen that rational emotive behaviour therapy is an approach which highlights the place of cognition in the development and continuation of personal problems. Another, more recent development called solution focused brief therapy (SFBT) picks up on the theme of cognition or thinking in the context of psychotherapy. However, the difference here is that SFBT also encourages clients to think in terms of mental well-being and finding solutions to the difficulties they experience. It is true, of course, that all forms of therapy are meant to empower clients in this way, but a key element of SFBT is that it emphasises health rather than psychopathology, and encourages a focus on achieving this more positive goal. There is a contrast here with psychodynamic counselling, which, for example, looks for deep underlying and pathological causes of personal problems. These problems, when identified, can then be addressed only through insight and an understanding of the way they are maintained in the present. Solution focused brief therapy could be summarised, therefore, as a form of psychotherapy which looks at solutions rather than problems, is future orientated, and draws on clients' strengths and personal resources rather than dwelling on their failures in the past. It is described as a brief approach because its practitioners believe it requires fewer sessions than other counselling models, but its briefness does not imply that it is limited to a predetermined number of sessions or a set time scale.

Solution focused brief therapy was developed and pioneered by Steve de Shazer and his colleagues who worked at the Brief Family Centre in Milwaukee USA from the mid-1980s. However, an important seminal figure in the approach was an American psychiatrist called Milton H. Erickson who died in 1980. O'Hanlon and Weiner-Davis (2003) describe Erickson's unique and often creative approach to helping clients to find solutions to their problems. Erickson's methods, though ostensibly eccentric, seemed to work well, not least because they focused on clients' competence, capabilities and individual strengths. Later on de Shazer extended some of Erickson's innovations, and eventually the framework for SFBT was established.

Though SFBT continues to grow and evolve, its underlying assumptions remain constant. In their description of the model, O'Hanlon and Weiner-Davis (2003: 34) identify a number of these assumptions, including the following:

'Change is constant.' Since the whole universe is in the process of ongoing change, it is fair to say that clients' problems are not static but are changing too. In SFBT, therefore, the counsellor steers the focus away from how the client's problems have been or are, and towards the

ways in which they are changing. Often clients don't see the change until they are invited to consider it.

It is not necessary to gather extensive background information about a problem in order to resolve it. Practitioners of SFBT believe that counsellors can spend too much time seeking information about problems when they should be spending time on solutions.

It is not necessary to know what caused a problem in order to resolve it. There is a contrast with other therapeutic approaches, in particular the psychodynamic model which emphasises the underlying cause or function of a client's problem. But even if a client 'knows' why she drinks too much, for example, it won't automatically alleviate the problem. In SFBT, therefore, the central aim is to overcome the problem by looking at solutions rather than underlying causes.

A small change will often bring about other beneficial changes in the client's situation. Often clients get depressed because it all seems too much. In SFBT a small initial change is seen as the catalyst for other bigger changes. According to O'Hanlon and Weiner-Davis (2003: 42) Erickson himself likened this effect to 'a snowball rolling down a mountain' – once it gets going it gathers momentum and substance.
Looking at Erickson's metaphor again we can see that change can also be very fast. SFBT practitioners believe in the possibility of rapid change and resolution of problems. In addition, SFBT practitioners believe that the therapist's belief in the possibility of rapid change will ultimately affect the client's perception of what is possible in a short space of time. Clients are the experts, they have the resources and they define their own goals. Although counsellors who use the SFBT approach have theoretical as well as practical training, they acknowledge that all clients are unique and know their own situations better than anyone else. In SFBT solutions should be formulated to meet those unique needs rather than the dictates or needs of a particular set of theories.

Skills used in solution focused brief therapy

The way in which language is used by the counsellor is especially significant in SFBT. One aspect of this is the practice of matching the client's language. This is seen as a means of joining the client and establishing rapport. If, for example, a client describes having a 'barney' with her partner, the counsellor should use this term too to mirror what has been said. To respond to the client by saying 'so you had a fight' would distort what was actually said and would alter the meaning significantly too. Solution talk is, however, always encouraged, and though clients may want to communicate in terms of problems and difficulties, the SFBT practitioner will seek to concentrate on solutions and will encourage the client to do the same. The counsellor will always ask open questions, designed to encourage positive ways of considering change. These are some examples:

- What progress have you made since last time?
- What are your hobbies and coping strategies?
- How will you know when you have reached that goal?
- What positive things have been happening at home?

Language is also used to 'normalise' situations or events in the client's life. These may be ordinary situations or issues which the client sees in pathological or extremely negative terms. An SFBT therapist might, for example, respond to what a client describes by saying, 'Oh that happens sometimes. It's fairly usual.' As O'Hanlon and Weiner-Davis (2003) point out, this is a technique or skill often used by doctors to allay their patients' anxieties. During the first session rapport is established between counsellor and client. After this, there is a fairly rapid focus on positive solutions and establishing goals. From the outset, solutions rather than problems are highlighted. The counsellor is likely to ask an initial question couched in positive terms, for example, 'What is it you would like to achieve here?' as opposed to 'What is the problem?' During subsequent sessions, positive change is assessed and details of it established. Any positive change which has taken place is acknowledged, amplified and reinforced by the counsellor's responses to the client. This is a way of giving indirect compliments to the client, and is meant to maintain the progress she has made.

The evolving role of brief therapy

The description of SFBT given here is a summary and is meant to convey an impression only of an approach which is relatively new to counselling and psychotherapy. Practitioners of SFBT are enthusiastic about its quick and effective results. However, not everyone is a fan of brief forms of therapy, and as we saw in Chapter 1, Yalom (2004) in particular expresses reservations about brief therapy and questions its ability to survive long term in the therapeutic field. Yalom (a psychotherapist with many years' experience of working with clients) refers to brief cognitive behavioural therapy in particular, but his main criticism is directed towards the 'astoundingly brief periods of time' in which new forms of psychotherapy generally are now delivered. SFBT is certainly often delivered this way (sometimes in just one session) and this is exactly how de Shazer (1985) intended it to be used. Doctors and other health care professionals often recommend brief cognitive behaviour therapy for their patients, so there is every possibility that SFBT will, because of its brevity and focus, become popular in the health sector too. However, as we have noted, a major criticism of brief therapy is that while it may help clients in the short term, the beneficial effects may not last. Critics, including Yalom, insist that initial gains in brief therapy may not be maintained because real progress requires 'characterological change' which can be provided only by longer forms of therapy (Yalom, 2004).

No doubt the debate about brief therapy, including SFBT, will continue and research will also continue to highlight the relative merits of different forms of psychotherapy and counselling generally. In the meantime, for those students interested in the approach, a number of books on the subject of SFBT is included in the Further reading list at the end of this chapter, along with relevant websites.

EXERCISE

The miracle question

In SFBT the focus is always on looking at the solution aspect of each client's situation. This solution principle underlies a technique called the 'miracle question' which is central to this approach. Working individually, think of a difficulty that you currently have. Then answer the following question which is based on de Shazer's original technique (de Shazer, 1988):

Suppose that one night when you went to sleep, there was a miracle and your problem was solved. When you woke up in the morning, how would you know it was solved and what would be different?

COMMENTARY The answer to this question should give you some idea of what your future would be like without the problem. In SFBT terms, this vision of a problem-free future should act as a catalyst to help you achieve it. Discuss your response to the exercise with members of your training group, saying how effective or otherwise you believe it to be.

Cognitive behaviour therapy today

The profile of cognitive behaviour therapy (CBT) has steadily increased in the UK within recent years. As I indicated in the introduction to this book, the enhanced prominence of CBT as a therapy of choice is linked to the Improving Access to Psychological Therapies (IAPT) initiative, which Lord Richard Layard tabled in 2005. In Lord Layard's view, provision of access to psychological therapies would help people suffering from depression and anxiety, and would, moreover, have the added benefit of helping those who had been out of work to resume employment. Lord Layard envisaged treatment centres which would offer evidence-based therapy and support to those who needed it, and in 2008 the Health Secretary, Alan Johnston, announced the Government's intention to spend £173 million a year on CBT. This initiative was backed by the National Institute for Health and Clinical Excellence (NICE), which recommended CBT for use in anxiety-related conditions and in depression.

Another significant factor in the growing popularity of CBT as an effective approach for psychological problems is the proposed registration, by the Health Professions Council (HPC), of counsellors and psychotherapists. The impending regulation of counselling and psychotherapy means that there is greater emphasis on accountability in relation to the work therapists do with clients. In other words, there is a need for research-based and cost-effective therapy, which can be easily accessed by members of the public, and which is shown to produce results.

However, a further reason for the expansion of CBT as a preferred approach to helping clients with anxiety and depression is its evidence-based status within counselling and psychotherapy generally. Much research has been done on the effectiveness or otherwise of CBT, and the results indicate that it is 'highly efficacious' for a range of psychological problems (Cooper 2008). According to information about CBT on their website, the Royal College of Psychiatrists stresses that it has been shown to help with many other problems besides depression and anxiety. These problems include stress, phobias, bulimia, obsessive compulsive disorder, post traumatic stress disorder, bipolar disorder and even psychosis. Physical problems and anger management are mentioned here too, as are low self-esteem and fatigue. There are numerous research projects detailed on the internet which highlight the effectiveness of CBT for a wide range of psychological difficulties, and increasing numbers of practitioners, including doctors, nurses and health visitors within the NHS are being trained to use it.

The research-based effectiveness of CBT (which is by no means confined to the UK) has surprised many practitioners, who have been trained in, and use, other approaches to helping clients. Some, including Yalom (2004) have expressed reservations about the effectiveness of CBT in the long term. His basic concern is that any gains which clients make in the short term with CBT may not be maintained once they leave therapy. He also points to the fact that clients frequently make quick gains at the start of any therapy, a phenomenon which does not mean that their problems are satisfactorily resolved. Another critic, psychoanalyst Darian Leader, expressed his views in *The Guardian* newspaper, describing CBT as a 'quick fix for the soul' whose aim is to get rid of symptoms (Leader, 2008). He contrasts this objective with other psychotherapeutic approaches which seek to understand what a client's symptoms might actually be saying.

Other writers, including Moloney and Kelly (2008) acknowledge that aspects of CBT may be helpful, but highlight environmental factors (including social and economic deprivation) which frequently contribute to psychological distress. Ignoring these factors is, in their view, one way of saying that they don't really matter. Furthermore, encouraging clients to adjust their thinking in such circumstances is misleading for clients and therapists alike. In her discussion about CBT, Proctor (2008) a clinical psychologist whose special interest are ethics, politics and power, refers to the fact that CBT invests a great deal of authority in therapists who are believed to know what is best for their clients. She adds that very little thought is given to the dangers of such an assumption.

In relation to issues of power and control in CBT, it is worth remembering that Aaron Beck and Albert Ellis, the original pioneers of CBT, both began as psychoanalysts and later became disillusioned with their original training. Both were concerned to develop a form of therapy

which was more located in clients' actual experiences, and which did not require subscribing to Freudian theories about the past and its influence on the present. In addition, both Ellis and Beck wanted to develop a form of therapy which could be delivered in a shorter time span than traditional psychoanalysis; they envisaged CBT as a collaborative endeavour between client and therapist. As stated earlier in this chapter, the counselling relationship is seen as an egalitarian one, though this equality is not always obvious at the beginning of therapy. However, equality is a central aim as therapy progresses. To those who allege that CBT is authoritarian or controlling, Ellis (1962) pointed out that virtually all psychotherapies can be described in this way. This is because all therapists, on account of their experience and training in a particular field, are, in fact, always in some kind of authority. Neither Ellis nor Beck envisaged CBT as a static theoretical approach to therapy; instead they saw it as dynamic and evolving in a way which would meet the changing needs of clients.

Already there is evidence that CBT is changing to meet the diverse needs of clients. Many of these changes are linked to research, for as Palmer (2008) suggests, CBT is a pragmatic approach which is not weighed down by dogma or rigid adherence to one particular set of skills. These changes include incorporating aspects of other theoretical approaches to counselling within CBT, including person-centred empathy, techniques in mindfulness and awareness exercise, elements of Gestalt counselling and even aspects of object relations theory. Not everyone is happy with this developing eclecticism and some, including Loewenthal and House (2008) make the point that CBT could be accused of incorporating unscientific techniques while at the same time continuing to claim scientific credentials.

CBT and the internet

One area in which CBT has superseded all psychotherapeutic approaches is its seamless transferability to the internet. Online counselling is now well established, and when we consider that people use the internet for so many things today, including shopping, finance, banking, networking and research, it is easy to see why this transition has come about. CBT is delivered online in two main ways: the first mode of delivery is via self-help programmes which guide users step by step through them. It is difficult to see how programmes like these can possibly respond to individual user needs, but they are growing in popularity nevertheless. The second method is when CBT is delivered, in real time, by a therapist working online. Recent research carried out at Bristol University, and described by David Kessler in the medical journal, *The Lancet* (2009) concludes that CBT is effective for depression when delivered by a

therapist online in this way. The researchers infer from these results that online counselling could be used in future to broaden access to CBT generally.

One criticism of online counselling is the absence of a therapeutic relationship when counselling is delivered in this way. To begin with, non-verbal communication is missing, and since all approaches to psychotherapy highlight the importance of the relationship and of attending to non-verbal cues, it is important to ask what, if anything, can compensate for their absence when therapy is delivered online. However, it should be added that aspects of non-verbal communication are absent in telephone counselling too, but many clients still choose to access this kind of help. Another important point to remember here is that clients do, in fact, have a relationship with a counsellor when using the internet for help. It is just that the counsellor is not as visible or present as she would be in the traditional counselling context, but this may suit some clients, especially those who cannot access help in other ways. Additionally, there are clients with certain problems, disability or social phobia for example, or those who live in isolated or remote areas, who may feel more secure initially when receiving help in this way. The difficulty here is that problems of isolation and loneliness may be compounded if online help is used without any progression to social interaction or other forms of support.

We have seen that recent research shows online CBT counselling to be effective when it is delivered in real time by a therapist. There are, however, other aspects of this approach which need further study and research. These include ethical issues relating to the protection of client confidentiality and online identity. Proof of online counsellor training and accreditation is another area which warrants attention in the context of protecting clients from exploitation or abuse.

In spite of the reservations expressed by practitioners of other approaches to counselling and psychotherapy, it seems inevitable that CBT will maintain its popularity for the time being at least.

Summary

Behavioural and cognitive approaches to counselling were the subject of this chapter. In the first instance we considered the evolution of Behaviour therapy, and discussed the theories of learning which informed the approach. The contributions of Pavlov, Watson, Thorndike, Skinner, Wolpe and Bandura were highlighted, and placed in the context of therapeutic practice. Problems which are frequently dealt with in behaviour therapy, including phobias, anxiety and social skills deficit, were discussed and examples of techniques used were also given. The aims of therapy, the nature of the counsellor/client relationship, goals

and group practice were outlined and several major behavioural methods and procedures were described in some detail. Reference was made to the cognitive emphasis in therapy, and the work of Albert Ellis and the rational emotive behaviour therapy which he pioneered was the subject of the second half of the chapter. The development of Ellis' approach was considered, along with the factors which influenced his work. The ABC model was shown, and a summary of irrational beliefs was given. Aims and objectives of therapy were included, and counsellor characteristics and examples of techniques and procedures were outlined. The nature of the counsellor/client relationship was discussed, as was the application of rational emotive behaviour therapy to group work.

We also considered another, newer form of therapy called solution focused brief therapy (SFBT). This innovative approach is future orientated and highlights solutions to problems rather than causes. Although SFBT is described as 'brief' it is not limited to a set number of sessions, nor does it have a specific time frame. There is a current trend in counselling towards abridged forms of therapy which produce quick results for clients. Health professionals, in particular, value brief therapy, since it is less expensive than longer therapy, and accommodates a greater number of clients in a shorter space of time. Some psychotherapists, especially those working from traditional perspectives and using more established therapeutic approaches, have questioned the long-term effectiveness of SFBT. The fact remains, though, that brief forms of counselling have tremendous appeal to many practitioners, especially when they see quick results with clients who don't have the time or resources to access longer forms of psychotherapy. SFBT and other forms of brief therapy meet the demands of the marketplace, so there is every reason to suppose that their popularity will increase exponentially in line with that demand.

Finally, in this chapter on behavioural and cognitive behavioural approaches we looked at the rapid development of CBT as a therapy of choice (including internet provision) and outlined some of the research findings relating to it. We also pointed to some of the criticisms levelled against CBT and highlighted the evolutionary factors underpinning its prominence within psychotherapy and counselling today.

HANDOUT/OHP NO 10

Key figures in the evolution of behavioural and cognitive approaches:

- Ivan Pavlov
- J. B. Watson
- E. L. Thorndike
- B. F. Skinner
- Albert Bandura
- Joseph Wolpe
- Hans J. Eysenck
- Aaron Beck
- Albert Ellis
- Milton Erickson
- Steve de Shazer

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Resources

Websites

www.beckinstitute.org
Information about Aaron Beck and the Beck Institute

www.babcp.com
The British Association for Behavioural and Cognitive Psychotherapies (BABCP)

www.rebtnetwork.org
Describes the work of Albert Ellis, as well as the theory and practice of Rational Emotive Behaviour Therapy (REBT).

www.solutionfocused.org.uk
Information about solution focused therapy.

www.iapt.nhs.uk
Information about the Improving Access to Psychological Therapies (IAPS) programme.

www.moodgym.anu.edu.au
This is a well-designed self-help programme which teaches CBT skills to people with anxiety or depression.

Journals

Behavioural and Cognitive Psychotherapy
This is the journal of the British Association for Behavioural and Cognitive Psychotherapies.

The Cognitive Behaviour Therapist
This is the online journal for cognitive behaviour therapists.