**Let’s put the ‘T’ back into CBT**

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**Abstract**

Purpose: The current manner in which cognitive behavioural therapy is delivered is critiqued, with a focus on the impact of evidence-based practice.

Design/methodology/approach: This paper is based upon the experiences, ideas and clinical practice of the authors.

Findings: The reductionist approach based on psychiatric diagnosis is put forward as the mechanism by which CBT has gradually lost its status as a form of psychotherapy.

Originality/value: An alternative framework based on revitalising CBT as a client centred, problem-based, and formulation driven form of psychotherapy is put forward.

Keywords: Critique; Cognitive behavioural therapy; IAPT; Formulation

**1. Introduction**

Can you imagine computerised existential psychotherapy? Or even better, a mobile phone app that delivers psychoanalysis? We can’t either; however, another model of psychotherapy is frequently available online, via self-help books or in brief workshops. That model of psychotherapy is Cognitive Behavioural Therapy (CBT). CBT is now seen, by many, simply as a set of interventions and techniques rather than a form of psychotherapy, which is how it started. This paper will examine this ideological shift and propose an alternative perspective. This is a reflective paper and the viewpoints put forward arise from the clinical experience of the authors, an awareness of current practice and an appreciation of existing literature.

CBT is an umbrella term for different types of psychotherapies, often with conflicting theoretical frameworks. Dissatisfaction with psychoanalysis led a psychologist (Albert Ellis) to draw upon Stoic philosophy and develop Rational Emotive Therapy and a psychiatrist and psychoanalyst (Aaron Beck) to develop Cognitive Therapy. These were intertwined, over a 30-year period, with the solid theoretical and research foundations of behaviour therapy to form CBT. Over time, sub-types of CBT flourished, with some returning to radical behaviourism, e.g. Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999); Buddhism, e.g. Mindfulness-based Stress Reduction/Cognitive Therapy; Kabat-Zinn & Hanh, 2009; Segal, Teasdale, & Williams, 2002); detailed laboratory work, e.g. Meta Cognitive Therapy (MCT; Wells, 1995); whilst others focused on specific populations, e.g. Dialectical Behavioural Therapy (DBT; Linehan, 1993) and Schema Therapy (ST; Young, Klosko, & Weishaar, 2003); to mention some of the leading perspectives. It is apparent that the CBT family has only weak bonds between its members if one considers the diversity of theoretical orientations and recommendations for practice. One of these bonds is evidence-based practice. Of note, Beck (1976; 1979) was one of the first to rely on psychiatric diagnosis when developing his theories. Given his professional background as a psychiatrist this is hardly surprising; however, his decision has had far reaching implications that affect virtually all psychological practitioners, applied researchers and most importantly the clients seeking help.

**2. A critique of current practice**

The construct of ‘evidence-based practice’ has been taken from evidence-based medicine (Sackett, Richardson, Rosenberg, & Haynes, 1997) and is thus highly entrenched in the medical model of mental health. The reliance on the randomised control trial (RCT) and associated meta-analytical procedures, is the hallmark of evidence-based practice. In order to increase the power of an RCT the groups under observation need to be as homogenous as possible. Classifying the participants using psychiatric diagnosis is the most common way of doing this, as is excluding any participants with complicated additional problems (co-morbidities), current excessive drug or alcohol use, problematic social issues, and basically anything else that distinguishes the participant as an individual. Before the intervention is delivered by experts in the field it has to be standardised or manualised to reduce any chance that non-specific factors may be responsible for the outcomes; and by outcomes we mean change in pre/post self-report questionnaires that attempt to measure psychopathology. Once the trial is complete and the results are favourable then the research findings are published. Researchers with a strong allegiance to the Cognitive Therapy model proposed by Aaron Beck were amongst the first to undertake RCTs.

For a time using the medical model seemed like an effective method for researching psychological distress (and developing an academic career). Step 1: Choose a psychiatric diagnosis that hasn’t been subject to the process yet; Step 2: Write a theoretical paper proposing the cognitive-behavioural element that keeps the disorder going; Step 3: Write a case study or two; Step 4: Apply for large grant and conduct RCT; Step 5: Write a treatment protocol; Step 6: Promote the model and associated treatment protocol across the Western world.

As the National Institute for Health and Care Excellence (NICE) guidelines came around for each psychiatric diagnosis time and time again the winner was CBT, in part due to there being a lack of studies using RCT methodology from other models of therapy; although this is starting to change with the inclusion of short term psychodynamic psychotherapy in the depression guidelines. Once CBT was getting the attention it is understandable that no one really challenged the new status quo. The medical model of CBT was here to stay. This is not to say that other ideologies were not present within CBT, for example research and guidance concerning case conceptualisation (Bruch & Bond, 1998; Persons, 1989; Kuyken, Padesky, & Dudley, 2009) or working with complex cases (Tarrier, Wells, & Haddock, 1998) and childhood trauma (Arntz & Weertman, 1999). But any real dissent from the medical model was not heard, it was not given a platform; perhaps to have done so would have loosened the grip that was currently held by researchers aligned to the medical model and allowed other models of psychotherapy to gain leverage.

For a while the clinician had relative freedom to work with their clients within a CBT model; the diagnostic focused evidence-based models could be adopted if they would benefit the client or more commonly idiosyncratic approaches would be used. Then came IAPT. The Improving Access to Psychological Therapy programme was created in 2004 by the psychologist, David Clark and the economist, Lord Layard. Initially the rationale underpinning IAPT was the economic argument; get people with anxiety and depression back into work, thus saving money in terms of unemployment or disability benefits. The new way of working was piloted in 2006 and rolled out in 2008. Most IAPT services are NICE guidance compliant and follow a stepped care model of delivery (Scogin, Hanson, & Welsh, 2003; NICE, 2004). Therapies/interventions are offered at different levels of assessed need; with the least experienced members of staff conducting the brief telephone assessments. Those perceived as requiring less intensive input receive low intensity or step two interventions (e.g., guided self-help or psycho educational groups) by a new type of work force, Psychological Wellbeing Practitioners (PWPs), typically psychology graduates with little previous experience of working within mental health services and directly trained at university for 25 days. Service users assessed as needing more thorough input are offered high intensity or step three interventions (e.g., CBT or counselling) by either pre-existing cognitive behavioural psychotherapists, clinical/counselling psychologists, and counsellors or new IAPT trained therapists; mental health professionals and later in the expansion of IAPT, ex-PWPs, directly trained for 60 days in a diagnostic driven, manualised version of CBT.

Whilst in the first wave of IAPT services NICE guidelines were being adhered to, with the contracting of services to non-NHS providers and payment by results, adhering to NICE guidelines started to be seen as optional rather than mandatory (Binnie, 2015). Session limits were reduced, often to only six sessions at step three, and caseloads increased. Recent survey-based research has indicated that 70% of staff working in psychological therapy services were stressed, 50% had feelings of failure and 46% were themselves depressed (Rao et al., 2016). A significant responsibility for this must fall on management of services and also the target-based system in which the services operate. Another such strategy is the dilution of CBT to increase productivity, with the watered-down versions of CBT still being called CBT, e.g. guided self-help and psychoeducational groups delivered by PWPs or by computerised cognitive behavioural therapy (CCBT). Even at step three therapists are expected to deliver a manualised approach for a diagnosis rather than tailor treatment with the client according to their idiosyncratic presenting problems. The therapist is seen as superfluous to the intervention or active ingredient; they are interchangeable (Binnie, 2015). David Clark has gone as far to say that therapists should not go ‘off-piste’ i.e. they should stick to the manual and ensure therapy ‘noise’ is reduced (Clark, 2016), i.e. when clients discuss how they have been feeling or wider aspects of their life. Compare Clark’s comments to those of Judith Beck ‘in real life practice cognitive therapists don’t use manuals at all’ (Beck, 2015).

Not only has IAPT had an impact upon what were primary care services, it has also infiltrated upon private practice. From personal observation many disillusioned IAPT practitioners have gone into private practice and this has created a flooded market. Nothing essentially wrong here, but due to the increased competition CBT often over sells itself. A brief Google search of local private practice websites brings up statements like “Helping you to achieve sustainable change as quickly and cost-effectively as possible”, or “CBT is proven to provide effective and permanent change”. This type of advertising leads to clients expecting ‘off the shelf’ interventions, a one size fits all approach; if these existed, and worked, then they would be freely available, and therapists would be redundant!

Due to the focus on evidence-based practice, the employment of RCT methodology to evaluate treatment effectiveness and diagnostic reductionism (epitomised in the national roll out of IAPT) CBT has been ‘diluted’ to such an extent where it becomes difficult to defend its status as a form of psychotherapy. Other models of psychotherapy do not appear to have this problem. Perhaps this is because they have a more comprehensive theoretical approach to being human, whilst CBT has relied on psychopathology and symptom reduction over the last 20 years (but not beforehand when formulation and problem focused forms where the dominant way of practising a client centred CBT, (e.g. Bruch & Bond, 1998). Indeed, CBT based books for practitioners read like an instructional guide, similar to a cook book. Many CBT practitioners will not see certain clients as they do not know how to treat their ‘disorder’ as they haven’t had the ‘specific’ training. This is not to say that people should work outside of their competencies, but the reality is that CBT practice when done professionally and ethically, cannot be reduced to a set of tools in a tool box. ‘I’ve been to the workshop on X disorder, I’ve studied the manual, I can now treat people with X’. Statements similar to this are common within psychological therapy services. These workshops by the experts in the field and the associated academic books are often a re-hash of standard CBT practice. CBT for depression, CBT for social anxiety, CBT for psychosis; whatever happened to CBT for people or better yet CBT with people?

One outcome arising from CBT closely aligning itself with psychiatry is that the concept of psychiatric diagnosis rarely gets challenged, even by professionals trained in psychological ways of thinking. Perhaps the pay-off is worth it? Perhaps there are more NHS jobs now for CBT practitioners due to this unholy alliance? Perhaps there is more research funding available if diagnostic codes are used? The role of psychiatric diagnosis permeates not only psychological practice but also how the NHS services are designed. Community teams are now split along diagnostic categories; with service users getting a ‘dose of CBT’ alongside their psychiatric medication. The majority of psychological practitioners, academics and service managers all know that the system of psychiatric diagnosis is theoretically redundant; with issues of validity and reliability frequently challenged (Kutchins & Kirk, 1999; Bentall, 2003). There is an acknowledged failure to find biomarkers of psychiatric diagnosis (Kupfer, 2013) and the disease model is challenged by the use of neuroleptics being recommended for not only those diagnosed with schizophrenia, but also for those diagnosed with bipolar affective disorder, depression, anxiety, personality disorder etc. (Kirmayer & Crafa, 2014). Even the words used to describe the disorders are overly technical (e.g. Hebephrenic schizophrenia), meaningless (e.g. GAD – Generalised Anxiety Disorder), offensive (e.g. Borderline Personality Disorder) and full of medical protectionism; think of *dysthymia*, for example; the Greek for ‘low mood’. Admittedly, a formal diagnosis can serve a function for people suffering with their problems, it can give recognition and a word that they can Google. But why use these words to describe people’s problems, when the words have no real meaning? Perhaps we should start using the associated codes instead; ‘I diagnose you with 296.32’, would be just as appropriate. Maybe it would be better to just focus on the difficult experiences themselves.

**3. An alternative framework**

The re-focusing on the experiences of service users has been put forward several times before within the academic literature. Boyle and Johnstone (2014), for example, suggest that the current diagnostic paradigm has comprehensively failed and that alternative systems based on specific experiences and contextual factors should be included in any new framework of understanding. Bentall (2003) recommends that the focus should again be on client’s experiences, and, through doing so, a need for a diagnosis becomes redundant; “Once these complaints have been explained, there is no ghostly disease remaining that also requires an explanation. Complaints are all there is” (p.141). By focusing on the experiences themselves, rather than on the disease model explanations, the idea of conceptualising (and therefore normalising and de-stigmatizing) such experiences on a continuum becomes possible (BPS, 2000). An experience-based approach naturally leads onto a skill set that psychological therapists have in abundance; this skill is psychological formulation.

Psychological formulation is the process of using psychological theory and evidence to collaboratively make sense of the development and maintenance of a client’s difficult or distressing set of experiences and presenting problems. This process can also be undertaken with families, teams and other systems (Johnstone, 2013). The purpose of formulation is to inform the way forward, whether this be through intervention, making recommendations or to simply aid understanding of the presenting problems and instil hope. Often, a formulation is an intervention in and of itself through the process of normalisation and reassurance (Johnstone, Whomsley, Cole & Oliver, 2011) and through understanding the function and inter-linking of the problems presented (Ezzamel, Spada, & Nikčević, 2015; Spada, 2006). However, as taught in IAPT style courses, this is not the message that is learnt. IAPT trainees are taught to formulate in accordance to a diagnostically based model rather than understand how the (typically) many presenting problems operate in interaction; this not only reinforces the disease model but also leads to therapists reaching for the treatment manual for the ‘disorder’. Formulating with the person is a different skill set to applying a diagnostic model-based form of CBT for the client.

We are not advocating throwing the baby out with the bath water. Most diagnostically-based models and associated treatment manuals contain useful ideas and interventions that can be incorporated into work with clients experiencing distress. What is being put forward, by the authors, is that CBT should not be designed for a client’s presumed diagnostic ‘entity’, and that the person should not be ‘fitted’ into a pre-existing model based on such entity and ‘delivered’ the associated ‘treatment’. The formulation should be constructed and adapted, in an organic fashion, in collaboration with the client based on their experiences and making sense of all the presenting problems. Yes, CBT will always be problem focused but how these problems are defined should not be based on diagnostic categories. The therapy itself should follow on from the formulation and have explicit links with it that are personalised, tailor-made and account for multi-problem complexity. If selected interventions detailed in a manual fit the formulation, and are likely to help the client, then they should be incorporated in the therapy. The idea of having a detailed, session-by-session pre-existing treatment plan before understanding the complexity of the problems, or indeed before meeting the client, seems erroneous.

In the same way that aspects of models and selected interventions derived from evidence-based research from a CBT perspective can be integrated into practice so too can elements from other models of psychotherapy as long as they make theoretical sense. There is some consensus that there are more commonalities between models than there are differences (Goldfried, 1995). Of course, this depends on the training, experience and knowledge of the practitioner. However, if an element of another model or a specific intervention can be incorporated into CBT the well-trained therapist should be the ultimate judge if doing so is appropriate. The preferred model of integration would be an assimilative approach (Lazarus & Messer, 1991; Messer, 1992), whereby these aspects from other models of psychotherapy are incorporated into the ‘host’ model, namely CBT. This process already seems to be occurring due to the wide umbrella of CBT approaches. An example would be how working with values from an ACT perspective is comparable to features of existential psychotherapy.

The focus of all psychotherapies is the client and their experiences and associated meaning making. Constricting the ability of psychotherapy to do this through evidence-based practice or through tribalism is a disservice to the client. Taking a pragmatic approach that is still theoretically sound may be the best way forward.

**4. Conclusion**

This paper is a call for the readership to throw away the diagnostic manuals, to stop using language based on the disease model; no more ‘mental illness’, no more ‘symptoms’, to re-think with clients what the concept of recovery means to them. To see CBT as an umbrella term for various methods all with strong theoretical underpinnings that can inform the process of tailor made formulations. So, let’s put the ‘T’ back into CBT; or better still reignite the term CBP and rightly declare that cognitive behavioural psychotherapy is a model of psychotherapy and is distinct from cognitive behavioural interventions or applications.

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