

CBT and Christianity

*Strategies and Resources for Reconciling
Faith in Therapy*

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Introduction

Topics in Chapter 1

- A historical view of spirituality, religion and psychotherapy
- The development and dominance of cognitive therapy as a psychotherapy
- The importance of Christianity in the West
- The appreciation of the role of non-specific factors in psychotherapy
- Interest in the Buddhist technique of ‘mindfulness’
- Findings relating religious adherence to positive mental and physical health
- The growing respect for cultural and individual differences
- The decline of logical positivism and the rise of postmodernism and social constructionist theory
- The question of a logical connection between cognitive therapy and the teachings of Jesus
- A general outline of the book

A historical view of spirituality, religion and psychotherapy

Psychotherapy, a form of treatment for people suffering from emotional and behavioural disorders such as anxiety disorders, had its major period of development during the twentieth century. With rare exceptions, for most of this time there was seen to be little connection between the conduct of psychotherapy on the one hand, and spirituality and the practice of religion on the other. Two very significant figures in the development of psychotherapy, Sigmund Freud and Albert Ellis, have taken an essentially negative view of religion. Freud saw it as an illusion and the result of wish fulfilment in terms of longing for the father (Wulff, 1996). Ellis (1980) contended that all forms

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of religious belief were pathological and lead to neurosis. For much of the twentieth century the view prevailed that values, including religious values, could be kept out of psychological theory, research and practice (Patterson, 1958, cited in Bergin, Payne & Richards, 1996).

Developments in general psychology for most of the twentieth century were also antagonistic to the exploration of the relevance of religion to psychotherapy. In the economic crisis after World War I the United States of America shifted to a preoccupation with scientific progress and economic success. Within psychology this was paralleled by the 'spectacular success of behaviourism and its ideal of an objective and mechanistic science' (Wulff, 1996, p. 45).

At the beginning of the twenty-first century it is appropriate to reconsider the issue. The divorce of psychotherapy from religion may never have been logical nor appropriate, and there have been developments that make it timely to consider the potential for integration of religion and psychotherapy. Some of these developments are: the development and dominance of cognitive therapy as a psychotherapy; the appreciation of the role of non-specific factors in psychotherapy, including the role of values; the interest in the Buddhist technique of 'mindfulness' by a number of respected authors within the cognitive therapy tradition; the finding that 'intrinsic' religiousness is positively related to mental health; the growing respect for cultural and individual differences; the decline of logical positivism and the scientific worldview and the rise of postmodernism and social constructionist theory; and cultural changes in Western society.

The development and dominance of cognitive therapy as a psychotherapy

Cognitive therapy is a psychotherapy that aims to assist people with emotional disorders such as the anxiety disorders, and depression. It has also been used with a wide variety of other disorders, including chronic pain, eating disorders and personality disorders. Cognitive therapy considers that emotional disorders, such as depression, are caused and/or maintained by faulty thinking. It works by the therapist using a variety of verbal and intellectual techniques to assist the patient to identify and change the dysfunctional beliefs and thought processes. Cognitive therapy (CT) was developed by Aaron T. (Tim) Beck in a series of books and papers in the 1960s and 70s, most notably Beck (1976) and Beck, Rush, Shaw and Emery (1979). CT continues to be refined by Beck and others (e.g. J. S. Beck, 1995). It is aligned with other therapies with a similar view of psychopathology and focus of treatment, including cognitive behaviour therapy (e.g. O'Donohue & Fisher, 2012); cognitive restructuring therapy (e.g. McMullin,

2000); rational emotive therapy/rational emotive behavior therapy (e.g. Ellis & Harper 1975; Ellis & Grieger 1977); acceptance and commitment therapy (e.g. Hayes, Strosahl & Wilson, 1999); and mindfulness based cognitive therapy (e.g. Segal, Williams & Teasdale, 2002).

Cognitive therapy is accepted by the American Psychological Association as a 'well-established' treatment for depression, a very common mental health problem, and is a component in about half of the psychological therapies considered to be well-established treatments by the clinical psychology division of the American Psychological Association (Chambless, et al., 1996, 1998; Task Force on promotion and dissemination of empirically validated psychological treatments, 1995), The relationship between cognitive therapy and cognitive behaviour therapy is complex and has been subject to misunderstandings and, in some cases, mislabelling of a particular therapy. Cognitive behavioural therapy was originally the integration of cognitive phenomena into traditional behaviour therapy, but in popular understanding it has come to mean the reverse. The following is a representative definition:

Cognitive therapy is a psychosocial (both psychological and social) therapy that assumes that faulty thought patterns (called cognitive patterns) cause maladaptive behavior and emotional responses. The treatment focuses on changing thoughts in order to solve psychological and personality problems. **Behavior therapy** is also a goal-oriented, therapeutic approach, and it treats emotional and behavioral disorders as maladaptive learned responses that can be replaced by healthier ones with appropriate training. **Cognitive-behavioral therapy (CBT)** integrates features of behavior modification into the traditional cognitive restructuring approach. (Encyclopedia of Mental Disorders, n.d.)

Arden and Linford (2009, p. 55) define 'Pure CBT' as follows:

Pure CBT – as opposed to the elements of it many of us employ in our practices – has five components

1. Psychoeducation
2. Breathing retraining
3. Cognitive restructuring
4. Exposure
5. Relapse prevention

The situation is further complicated in that Beck's original 'Cognitive Therapy of Depression' (Beck et al., 1979) included a large behavioural assignment component. Thus both 'cognitive therapy' and 'cognitive behaviour therapy' include attempts to change both thoughts and behaviour directly.

It is this set of components that has been very successful in achieving outcomes for people with emotional and behavioural disorders by assisting people to change their thinking and their behaviour without recourse to attempts to change anatomy or physiology. The CT-CBT approach has outperformed other non-physiological/non anatomical approaches. It has also largely been a 'Western' phenomenon. It is therefore appropriate to consider the relationship of CT-CBT with the dominant religion of the West: Christianity.

The importance of Christianity in the West

The teachings of Jesus, a first-century Palestinian Jew from Nazareth, a small town in the north of Israel, are important to a very large number of people. Christianity, the religion based on those teachings, is unarguably the world's most popular religion with two billion adherents. The point prevalence for depression in adults ranges from 2–3 per cent for men and 5–9 per cent for women (American Psychiatric Association, 2000). Therefore between 40 and 180 million people with an adherence to Christianity are likely to be suffering from depression at any point in time, not to mention at least the same number who suffer from one of the many other disorders, including anxiety disorders, that benefit from cognitive therapy.

Many people with depression and other emotional disorders will (or should) receive CT as a component in their treatment. Many of these people, particularly in the West, will be practising Christians. If there are connections between the teachings of Jesus and CT, and if the teachings of Jesus can then be integrated positively with CT, clearly it could be very beneficial for people receiving CT who have Christian beliefs.

The appreciation of the role of non-specific factors in psychotherapy

Since the discovery in the mid 1980s that all psychological theories appear to have about the same positive effect on symptoms of disorders such as depression, interest has developed in the so-called non-specific effects of therapy. These are factors that are not necessarily derived from the theory the therapy is based on, but which affect therapy, or occur in the context of therapy. They have included the therapeutic alliance, and client factors such as motivation for therapy and expectancy of success in therapy. A non-specific

factor explored explicitly in the context of psychotherapy is the role of both the therapist's and the client's values in therapy. Bergin, Payne and Richards (1996, p. 301) claim that 'Experiencing empathy for clients, knowing something of their struggle and identifying with their dilemmas depends upon comprehending their beliefs, their moral framework, and their assumptive world'. These authors believe that helping people clarify their own values may be the most important aspect of therapy (1996, p. 302). An implication of this work is that the compatibility of the therapy with the client's values and expectations may enhance the effectiveness or the acceptability of psychotherapy, either directly or by enhancement of a known non-specific factor such as the therapeutic alliance. Values are often considered to be important aspects of a person's religion, so it follows that being able to engage with the source of a person's values in psychotherapy will enhance the efficacy of therapy.

Interest in the Buddhist technique of 'mindfulness'

Mindfulness trains people in 'non-judgemental awareness' of bodily sensations, thoughts, and feelings. These thoughts and feelings are viewed as passing events in the mind. The technique was introduced to clinical psychology by Marsha Linehan (1993) as part of her 'dialectical behavior therapy' (DBT), a form of cognitive behaviour therapy developed for people with borderline personality disorder. It has since been applied in the treatment of a number of disorders and problems. Furthermore, Teasdale and Barnard (1993) have seen mindfulness as fitting with their interacting cognitive subsystems model of depression, and, with other colleagues, Teasdale has developed a mindfulness based programme of therapy to prevent relapse in persons with depression (Segal et al., 2002).

Mindfulness was explicitly derived by Linehan from 'Eastern spiritual practices' (1993, p. 144), notably Zen Buddhism. Linehan introduced Segal, Williams and Teasdale to the work of Jon Kabat-Zinn in Worcester, Massachusetts. Kabat-Zinn had developed 'mindfulness-based stress reduction' (MBSR) and had been using it with large numbers of people, including in groups of up to 30 at a time, for over ten years at that time. Segal and colleagues comment: 'The accounts of what his patients were getting out of his program bore a striking similarity to what we were beginning to see as the central change process in cognitive therapy' (2002, p. 41). If it is reasonable to incorporate Zen Buddhist practices into cognitive (behaviour) therapy, then it is also reasonable to consider the teachings of Jesus in the context of cognitive therapy.

Findings relating religious adherence to positive mental and physical health

The relationship between various aspects of religion, including intrinsic and extrinsic religiosity, spirituality and religious adherence, is a complex one (Gartner, 1996; Wiggins Frame, 2003). For example, Gordon Allport the great social psychologist in his seminal 1950 publication differentiated between extrinsic and intrinsic religiousness. Intrinsic religiousness was characterised by church attendance, reading the scriptures and other devotional literature, engaging in private prayer and meditation and living out religious beliefs in everyday life (Wulff, 1996). Determining the relationship between these aspects of the human experience and mental health/illness is even more complex. For the purposes of this book religious adherence and spirituality will be treated as a unitary phenomenon.

In a classic early meta-analytic study in the area, Bergin (Bergin, Masters & Richards, 1987) found that when religion was correlated with measures of mental health, 23 per cent of the studies revealed a negative relationship, 30 per cent found no relationship and 47 per cent found a positive relationship. Larson and Larson (2003) reviewed the relevance of spirituality/religious adherence to physical and emotional health. They found:

- Religious participation has been consistently linked with increased chances of living longer in a large number of large community samples.
- Although religious coping was not associated with longer life in acutely ill people, it was associated with better mental health status and social support.
- Contrariwise, in a study of over 600 people over 55 suffering from physical illness, those who were also suffering from religious distress had a greater chance of dying.
- Four studies with moderate to large sample sizes reported that people with persistent mental illness reported significant assistance from their religious beliefs.
- Religious participation reduces risk of suicide. In 68 studies, 84 per cent found lower rates of suicide or more negative attitudes towards suicide.
- Religion and spirituality are also associated with lower rates of depression. A review of over 100 studies found that religious and spiritual factors are consistently associated with lower rates of depression.
- Therapy is slightly more effective when it is oriented to people's religious beliefs. This is especially the case when the therapy is conducted by a therapist who does not have personal religious adherence.

- Spiritual/religious involvement is associated with lowered risk of alcohol and drug dependence, and is a component of the 12-step programmes which are some of the most respected treatments for substance abuse and dependence.
- Spiritual and religious factors contribute to successful outcomes of surgery and chronic medical illness.

This evidence of positive benefits of spirituality and religion upon physical and mental health, and especially in the domains in which cognitive therapy operates, suggests that there may be benefits in combining religion/spirituality and cognitive therapy. It also raises questions about the mechanisms of action of CT versus religion.

The growing respect for cultural and individual differences

Principle E of the APA Code of Ethics, Respect for People's Rights and Dignity states:

Psychologists respect the dignity and worth of all people... *Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socio-economic status and consider these factors when working with members of such groups.* Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. (my emphasis)

This supports the recognition of, and sensitivity to, 'differences' in provision of psychological services (which includes psychotherapy). Whether or not practising Christians are becoming a minority in Western countries, that religious allegiance certainly constitutes a 'difference' from non-Christians that is important to the people concerned, and that ethical guidelines, such as those of the APA, are exhorting psychologists to consider.

The decline of logical positivism and the rise of postmodernism and social constructionist theory

Jones (1996, p. 118) has written 'The traditional or positivistic view of science has been eroding since the late 1950s'. It has become accepted that theory is value laden. Postmodern thinkers have promoted the idea that all

reality is socially constructed (Wiggins Frame, 2003); therefore the door is opened for religious and spiritual phenomena to be the object of scientific investigation. While that is not a primary aim of this book, an investigation of the relationship between the teachings of Jesus and cognitive therapy may throw up aspects of both that could be the focus of scientific investigation.

Thus there are a number of powerful reasons why we should consider the potential for integration of cognitive therapy with the teachings of Jesus. To summarise:

- Both CT/CBT and Christianity are important in contemporary Western society. Lots of people are suffering from the disorders that CT/CBT has been shown to be effective in treating. It follows that many of these will have some degree of allegiance to the Christian religion.
- Positive spirituality and religious practice are associated with positive mental health outcomes.
- Ethical guidelines encourage psychologists to consider the differences (or, better, the distinctiveness) of their clients. This includes the degree and nature of the clients' religious adherence.
- The process may generate some questions for scientific analysis.

This book will consider the integration of the teachings of Jesus into cognitive therapy. For there to be benefit from such an exercise there would need to be logical connection between the two, significant cross-contribution and sufficient compatibility in content. It would not be appropriate to attempt two fields of endeavour with no logical connection.

The question of a logical connection between cognitive therapy and the teachings of Jesus

Cognitive therapy is a psychotherapy, and the teachings of Jesus are the teachings of an itinerant Jewish teacher and healer who lived in the first century of the Common Era (CE) that have been recorded and serve as the basis for the Christian religion. Although one is something that is primarily done with individuals, and the other with assembled groups of community members, there are a number of points of similarity: the main ones being that both are verbal, both are concerned with beliefs and both are concerned with improving the functioning of the hearers. It would seem at first blush that practice both of the Christian religion and CT have similar domains of operation.

A general outline of the book

The aim of this book is to provide a vehicle to allow therapists to engage with aspects of the Christian religion whilst doing cognitive therapy with their clients. Those aspects that can be engaged with include the beliefs, values and practices that are associated with the Christian religion. The first question is whether those beliefs, values and practices are (sufficiently) compatible for the exercise to be worthwhile. The first part of the book considers this issue. Here we consider:

- the core tenets of cognitive therapy
- the core tenets of Christianity. This will include an attempt to distinguish between the teachings of the historical Jesus of Nazareth and the teachings of the church as they have developed. This will involve a sojourn into twentieth-century Biblical scholarship, and into the social and political environment of the Eastern Mediterranean in the first century CE
- the degree and nature of compatibilities and incompatibilities between the two. It will be shown that there are a number of core compatibilities.

In the second part the compatibilities are addressed in detail and in the third therapeutic approaches are presented that integrate important aspects of the teachings of Jesus into cognitive therapy, both in terms of general approach, and in specific techniques and therapeutic strategies:

- Chapter 7 describes a general model for assessing people for cognitive behavioural therapy, and notes the most common areas in which Christian people may have cognitive difficulties that may be associated with their Christian faith.
- Chapter 8 discusses preliminary and general considerations when doing cognitive therapy with Christian people, including using logic as Jesus did.
- Chapter 9 introduces content based interventions and provides a general method for working with the clients' negative thinking from a Christian perspective.
- Chapter 10 considers the value of people in the teachings of Jesus and presents guidelines for applying them to attitudes to oneself and others.
- Chapter 11 considers Jesus' teaching about the relationship of the individual to God and presents guidelines for using that with clients.
- Chapter 12 considers the behaviour that Jesus prescribed for his followers.
- Chapter 13 integrates the preceding three chapters as a series of dialectics that lead to a way of thinking and behaving in which a Christian person can blend the teachings of Jesus with cognitive (and behavioural) therapy.

Introduction to Cognitive Therapy

Topics in Chapter 2

- General aspects of psychotherapy
- The basis of cognitive therapy
- Beck's cognitive therapy
- Rational emotive (behaviour) therapy
- Schema therapy
- Similarities amongst the three main schools of cognitive therapy

General aspects of psychotherapy

Most systems of psychotherapy can be considered in terms of the theory and the advocated practice. Standard texts will have one or more theoretical chapters and then a series of chapters on how the theory is applied in the process and content of psychotherapy. Sometimes the application is general, suggesting therapist behaviour that may be used in a piece-meal way across a number of sessions, and sometimes the application is sequential, suggesting a series of steps or phases that the therapist and the patient go through. Sometimes there are differences in guidelines across different disorders or across different configurations of symptoms or understandings of how the symptoms are caused and maintained.

Cognitive therapy (CT) is a psychological therapy (or psychotherapy) for emotional disorders, especially anxiety disorders, depression and excessive anger. It can be useful for other problems that have negative emotion as a base, such as addictions, and is useful in many aspects of normal life, including relationship and workplace issues. CT has also been used with some success in the more chronic behaviour disorders that are known as personality disorders,

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and with people with psychotic disorders such as bipolar affective disorder and schizophrenia. Knowledge of the principles of cognitive therapy is also helpful in general counselling and performance enhancement whether in the workplace or on the sports field.

All therapies have a 'primary premise', a proposition about what causes the dysfunction of persons wanting the therapy, and about what needs to be done to reduce or eradicate that dysfunction. In the case of cognitive therapy this is: one's *thoughts* influence one's emotions and behaviour, and that therefore changing one's thinking can contribute to the reduction or eradication of counterproductive behaviour and excessive negative emotion.

A psychotherapy may be disseminated in a number of ways. It can be disseminated from master to apprentice, as in a guild, with varying degrees of guardianship of 'the secrets'; it can be passed on through specific training by accredited trainers in institutes and universities, or in stand-alone workshops, courses or seminars, often organised by an interest group such as the Australian Association for Cognitive and Behaviour Therapies. It can be passed on by various forms of media including books, articles and various forms of electronic audio-visual presentation.

The presentation of therapies in such diverse ways, by different people, is not necessarily consistent. There can be differences as to what is encompassed by the labelled therapy, and there can be differences in opinion about the core concepts and practices of the therapy. The therapy may also evolve and change over time. It was enlightening for me to attend the first World Congress of Cognitive Therapy in Oxford in 1989 and find that other cognitive therapists (including Aaron T. Beck) were using techniques drawn from other schools of therapy, such as the 'empty chair technique', and seeing them as encompassed under the rubric of cognitive therapy.

I have already alluded to the issues around the meanings of the label 'cognitive behaviour therapy'. Let us therefore be clear that this chapter and 'cognitive therapy' or 'CT' in this book refer to the 'C' in CBT and to the various *cognitive* therapies developed in the late twentieth century that seek to reduce or eradicate counterproductive behaviour and excessive negative emotion by changing people's *thinking*.

The basis of cognitive therapy

The following is not meant to be a comprehensive orientation to cognitive therapy. There are many excellent books that accomplish that task at a number of different levels of theoretical sophistication. This chapter is concerned with extracting the essence of cognitive therapy, so that compatibilities and incompatibilities with Christianity can be determined.

As suggested by the label ‘cognitive’ (from Latin *cognoscere*, to know), cognitive therapy works on, or with, people’s *thinking*. There are a number of therapies that developed from the mid twentieth century that have concerned themselves with thinking. The main ones are Beck’s cognitive therapy, rational emotive therapy (RET) rational emotive behaviour therapy (REBT), cognitive restructuring therapy (CRT), schema therapy and metacognitive therapy.

A second set of therapies that are arguably cognitive but have a less prescriptive approach to cognitions and less specific focus on cognitive phenomena includes dialectical behaviour therapy (DBT), interacting cognitive subsystems therapy (ICST), acceptance and commitment therapy (ACT), and mindfulness based cognitive therapy. These are sometimes known as the ‘third wave’ of modern psychotherapies but will not be dealt with in detail in this book.

In the case of each therapy or set of therapies I will use what is generally considered to be the most recent authoritative basic text on the fundamental aspects of the therapy concerned, authored by the founder of the theory or a close ally.

Beck’s cognitive therapy

Let us start with Beck’s cognitive therapy. Aaron (Tim) Beck is a psychiatrist who became dissatisfied with the predominant psychoanalytic view of the cause and maintenance of depression. He wrote a number of papers in the 1960s, and in 1976 published the popularly accessible *Cognitive Therapy and the Emotional Disorders* which outlined his theory with respect to depression, anxiety disorders and anger. In 1977 the first outcome study was published in which the new therapy was compared to antidepressant medication. In 1979 the manual used in the outcome study was published as *Cognitive Therapy of Depression* (Beck et al., 1979). Since then there have been many books by Beck and his associates extending the use of cognitive therapy to other disorders, but probably the definitive book outlining the main features of the therapy is the book written by Beck’s daughter, Judith Beck: *Cognitive Therapy, Basics and Beyond* (Beck, 1995). That book will be used as the main resource for what follows.

The cognitive model

The *cognitive model* proposes that distorted or dysfunctional thinking (which influences the patient’s mood and behaviour) is common to all psychological disturbances. Realistic evaluation and modification of thinking produce an improvement in mood and behavior. Enduring improvement results from modification of the patient’s underlying dysfunctional beliefs. (Beck, 1995, p. 1)

An important principle of cognitive therapy is that the way people feel in a situation is associated 'with the way in which they interpret and think about a situation. *The situation itself does not directly determine how they feel;* their emotional response is mediated by their perception of the situation' (Beck, 1995, p. 14; emphasis original).

Important components of the cognitive model are *beliefs* and *automatic thoughts*. Beliefs are divided by J. Beck into *core beliefs*, *attitudes*, *rules* and *assumptions*. Core beliefs are the most central. According to J. Beck they are 'fundamental and deep' and are 'regarded by the person as absolute truths.' The content of these beliefs comes from childhood and is often about themselves, the world and other people.

Rules, *attitudes* and *assumptions* are intermediate beliefs. Rules appear to be specifications of necessary actions, such as 'I must work as hard as I can all the time.' Attitudes have some kind of value attached to an entity or attribute, as in 'It's terrible to be incompetent,' and assumptions are beliefs of the outcome of following a certain rule, as in 'If I work as hard as I can, I may be able to do some things that other people do easily.' Again, according to Judith Beck, these beliefs arise from people trying to make sense of their environment, usually during childhood.

These beliefs influence the person's perception, which is expressed by automatic thoughts, which in turn influence the person's emotions. *Automatic thoughts* are very quick thoughts or images which arise in our stream of consciousness, seemingly by reflex, in a given situation. They are short and specific. They occur extremely rapidly, immediately after the event. They do not occur in sentences, but may consist of a few key words or images. They do not arise from careful thought. They do not occur in a logical series of steps such as in problem solving. They seem to happen just by reflex. You do not summon them up, and you can't send them away. They seem reasonable at the time (adapted from Beck et al., 1979).

Cognitive distortions are errors in thinking, such as *all-or-nothing thinking*, in which the person views a situation as being one or the other of two categories instead of being on a continuum; *catastrophising*, in which the person predicts the future negatively without considering other, more likely, outcomes; and '*should*' and '*must*' statements, in which the person has a precise, fixed idea of how they or others should behave and overestimates how bad it is when those expectations are not met. These errors can be seen to involve misuse of logic or lack of logic. The misuse of logic involves drawing conclusions that are not justified by the information available, either because some information is ignored, or because the conclusion would require more information to be true. The lack of logic, as in the case of should statements, involves arbitrary thinking, in which there is no mechanical or physical law that supports the statement.

The cognitive phenomena addressed in cognitive therapy are quite different from each other. Automatic thoughts are specific to a situation, are transitory and occur for just a brief moment in time in the stream of consciousness. Cognitive distortions are attributes or descriptions of the *process* of thinking. Beliefs are continuous entities: they transcend situations and exist independently.

Core beliefs are described by J. Beck as being the most central ideas about the self. Although the term ‘core belief’ is often used interchangeably with the term ‘schema’; Aaron Beck, cited in J. Beck, suggested that schemas are *structures* in the mind and that core beliefs are the *content*, presumably of those structures. Judith Beck states that negative core beliefs fall into two categories: those associated with helplessness, and those associated with unlovability, though she does note other content areas such as ‘other people’ in that ‘Other people will hurt me’ and ‘The world is a rotten place.’ These last reflect Aaron Beck’s original ‘cognitive triad’ of three kinds of negative thinking: about the self, the world and the future.

The premise of cognitive therapy

The above has outlined the major aspects of the cognitive model. The task of the therapist is to identify those aspects of negative thinking and to assist the client to change them. There is an implication that some of the beliefs are on the surface, that is, they can be recognised by the therapist/and or the client, in the content of the client’s language in session or the client’s description of his or her thinking. There is also the implication that some of the beliefs, especially core beliefs, are difficult to access or to articulate clearly. There are a number of techniques for identifying core beliefs, but they will not be discussed further in this book. (See Beck, 1995 and Free, 2007, Chapter 10.)

Once the beliefs are articulated, they can be analysed, and examined in an objective way, and if the person chooses to, they can be changed or modified. Some of the techniques recommended by J. Beck are shown in Box 2.1. Other techniques can be found in McMullin (2000) and Free (2007). A number of techniques will also be presented in the second part of this book.

Rational emotive (behaviour) therapy

Rational emotive behaviour therapy (REBT) was developed by Albert Ellis over the same time period as Beck developed his cognitive therapy. Albert Ellis was a clinical psychologist who, like A. Beck, became dissatisfied with the psychoanalytic approach to therapy and felt that behaviour therapy inappropriately disregarded cognitive phenomena. Originally named rational emotive therapy

Box 2.1 Techniques used in cognitive therapy.

Socratic questioning	Core belief worksheet
Examining advantages and disadvantages	Extreme contrasts
Rational emotive role play	Developing metaphors
Acting 'as if'	Historical tests
Behavioural experiments	Restructuring early memories
Cognitive continuum	Coping cards
Self-disclosure	

(RET) the name was later changed to reflect its status as a behaviour therapy. The theory underlying REBT is largely a theory of the origin of emotions, in particular maladaptive emotions. There are some strong similarities between CT and REBT. Many of their central postulates are parallel, and the overall concept is very similar. The theories can be seen as complementary in many ways. In fact, in the *Handbook of Rational-Emotive Therapy* (Ellis & Grieger, 1977), the chapter on depression is contributed by Aaron Beck and Brian Shaw, who are both more usually associated with Beck's model of depression.

Much of the following is taken from *The Fundamentals of Rational Emotive Behaviour Therapy* (Dryden & Branch, 2008). Dryden was the first Briton to be accredited as an REBT therapist (in 1977) after training at the Albert Ellis Institute in New York and is probably the most prolific author in the area of REBT.

The starting point for REBT is the *situation*. A situation is a description that a person makes of an event. The event can be in the past, the present or the predicted future. The event can be internal (such as feelings or body sensations), or external. A situation consists of three components: the A, the B and the C. The A is those aspects of the situation which a person can discern and attend to (Dryden & Branch, 2008, p. 4). Of these some are 'critical'. *Critical As* are those aspects of the situation which a person can discern and attend to *that activate* the beliefs and emotional consequences that we are concerned with in the therapy at the time.

Critical As can be actual events, or they can be inferred events. According to Dryden and Branch we can make interpretations and inferences about events. Both involve going beyond the observable data. Dryden and Branch distinguish between interpretations, which they see as non-personal ideas about reality that go beyond the data, and *inferences*, which also go beyond the data, but which are personally significant for the individual.

REBT emphasises the importance of *beliefs*, the B part of the ABC. Beliefs are ideas, that can be expressed in words in sentences, that the person holds to be true.

The beliefs are either *rational* or *irrational*. Rational beliefs are flexible or non-extreme, consistent with reality, logical, largely functional in their emotional, behavioural and cognitive consequences, and largely helpful to the individual in pursuing his or her basic goals and purposes.

The themes of irrational beliefs are also specified. Originally Ellis (e.g. Ellis and Harper, 1975) listed ten irrational beliefs, but Ellis and Grieger (1977) identified four main types of irrational belief: 'awfulizing', 'can't-stand-it-itis', 'musturbation' and 'damning' of oneself or others. Awfulizing refers to exaggerating the negative consequences of the event to which the cognition refers. Can't-stand-it-itis refers to cognitions in which it is asserted that the person experiencing the cognition is, or will be, unable to stand the relevant event. Both of these types of irrational belief refer to concepts which Ellis believes are essentially undefined, that is, the concepts of 'awful' and being 'unable to stand' something. He believes that persons possess unexamined and virtually superstitious referents for these concepts. The referents are unexamined because the person will not have thought through what 'awful' or being 'unable to stand' something means, in terms of actual, physical outcomes. The referents are superstitious because the vague ideas and images that comprise them often refer to experiences that are worse than any which are physically possible.

The third category, 'musturbation', refers to a rule, or a set of rules, for the behaviour of oneself or others. The implication is that if one or another person does not behave according to a rule or rules, then it is awful, or one is unable to stand it. In addition, the rules may be impossible or virtually impossible to be complied with, such as 'I/he/she must be perfect'. Ellis believes that such rules are essentially arbitrary standards that the person may have internalised from a number of sources.

The fourth kind of irrational belief refers to making negative judgements about the worth of yourself or others, sometimes as a result of applying the arbitrary standards of 'musturbation'.

Dryden and Branch (2008) also identify four types of irrational beliefs: demands, awfulising beliefs, low frustration tolerance beliefs and self-depreciation/other depreciation/life-depreciation beliefs. Demands are preferences which are held as absolutes (similar to shoulds in Beck's cognitive therapy). Awfulising beliefs are negative beliefs about the *nature* of an entity that are absolute. Low frustration tolerance beliefs are absolute negative statements about being to survive a situation or condition as captured in the words 'I can't stand it'. Depreciation beliefs are beliefs that attach an absolute negative *value* to an entity or situation.

Irrational beliefs are rigid or extreme, inconsistent with reality, illogical, largely dysfunctional in their emotional, behavioural and cognitive consequences,

and largely detrimental to the individual in pursuing his or her basic goals and purposes. It can be seen that it is the *absolute* nature of the negativity of these beliefs that is the problem. REBT maintains that emotive disturbance is the result of the absoluteness of the irrational beliefs.

Dryden and Branch list four types of *rational* beliefs: non-dogmatic preferences, non-awfulising beliefs, high frustration tolerance beliefs and self-acceptance/other acceptance/life-acceptance beliefs. An important aspect of these beliefs is that they are *relative* and *non-extreme*. Rational beliefs are associated with effective emotional functioning.

REBT also recognises ‘action tendencies’. Action tendencies are associated with beliefs, but do not necessarily occur.

One major task that you have as an REBT therapist is to help your client to see the purpose of going against the action tendencies that are based on irrational beliefs and to develop alternate behaviours that are consistent with action tendencies that are based on the corresponding rational beliefs. (Dryden & Branch, 2008, p. 22)

REBT distinguishes between healthy and unhealthy emotions. Unhealthy emotions are unhealthy because they do not help clients to change their negative critical Bs. There is also an implication that the *quality* of negative emotion is subtly different from positive emotion, that is, concern (a healthy emotion) is qualitatively different from anxiety, and remorse (healthy) is qualitatively different from guilt. Different action tendencies apply in healthy versus unhealthy emotions. Dryden and Branch see *anxiety* as associated with the action tendencies of withdrawing physically or mentally from a threat, warding off the threat, tranquillising the feeling using substances, or seeking reassurance. In contrast, *concern* is associated with the action tendencies of facing the threat and dealing with the threat.

REBT acknowledges the importance of commitment to change, and Dryden has developed a worksheet approach to this which is very similar to one I developed (Free, 2007, pp. 344–346). An important aspect of REBT is getting commitment from the client for each major therapeutic activity. This was articulated earlier, in 1977, as three ‘insights’:

- Something causes a person’s own self-defeating behaviour and emotional disturbance.
- A person is upset because they keep indoctrinating themselves with irrational beliefs.
- Acceptance by the person that he or she must rigorously stay with rational beliefs and will have to work at this forever in order to remain undisturbed.

These can be seen as metacognitions by a client about the cognitive nature of their dysfunction. The action tendencies associated with these metacognitions are likely to be positive and beneficial for the person.

REBT also recognises meta-emotion, that is, emotions about emotions (Dryden & Branch, 2008, p. 97). An example is a person who feels guilty about being angry, or ashamed about being anxious. These are based on irrational beliefs as are primary negative emotions, so the same approach is used.

An important part of REBT is goal setting. It recognises that patients come to therapy with two kinds of goals: those concerned with reduction of distress and those concerned with the promotion of psychological health. Important aspects of this are that the goal is problem based and there is a tension or dialectic between the patient's report of the problem and the problem as translated into RET terms. There is also an acknowledgement that the patient's goals may be unrealistic, as in the cases of changing unchangeable impersonal negative events, changing other people or feeling neutral about negative events. In modern REBT it is seen as important to continually return to the patient's view as to what they want to change, and to what is most important to them.

Once the goals and irrational beliefs are identified in REBT, it is frequently necessary for the therapist to lead the client in 'disputing' the beliefs. Once a commitment to dispute has been established, according to Dryden and Branch (2008), following DiGiuseppe (1991), three major arguments are used in REBT to assist the client in moving from irrational to rational beliefs. These are empirical arguments, logical arguments and pragmatic arguments. Empirical arguments compare the patient's belief with the real world, logical arguments use the rules and principles of logic to show the belief is irrational, and pragmatic arguments put the patient's beliefs in the context of the outcome of holding those beliefs. These are quite similar to the 'analyses' of Free (1999, 2007) which are in turn based on the approach of McMullin (2000) and McMullin and Giles (1981). These and other arguments are used in two approaches: Socratic disputing and didactic disputing. In Socratic disputing the therapist thinks he or she knows what is irrational about the belief and asks questions to have the client articulate and dispute the issue. At the most basic that would be (using an *empirical* approach) something like: 'What would be the evidence for ...?'

More complexly the questions might be asked in a stepwise sequence with the same objective. In didactic disputing the therapist presents the reason for the irrationality of the belief in the form of an abstract principle: 'For any belief to be rational there has to be a majority of evidence in the real world that supports that belief.' Dryden and Branch advocate a mixture of Socratic and didactic disputing with cautious use of didactic disputing. In both cases the

therapist develops a proposition with the client that is incompatible with the client's original belief and brings it into juxtaposition with the original belief. Presumably the patient changes their beliefs because the knowledge that the beliefs are more consistent with the real world or more logical, or less practical, leads to belief change.

In addition to dealing with specific problems as described, Dryden and Branch also see people in REBT as pursuing personal development goals: enlightened self interest, flexibility, acceptance of uncertainty, commitment to vital absorbing interests and long-range hedonism. These are addressed after the more immediate goals, and only for interested people.

The parallels between REBT and Beck's theory are clear. Both refer to a distorted process of thinking which leads to beliefs that are inconsistent with objective reality. The domains of these beliefs are also very similar: they are concerned with value of self and others, and the badness or danger of particular events. It is also clear that although REBT refers to beliefs, inherent in this is the logic that was used to formulate the beliefs. The implication is that the logic used in the derivation of irrational beliefs is distorted, just as in the 'cognitive distortions', or 'logical errors', in cognitive therapy, however REBT considers that the same inferential processes occur in healthy and unhealthy emotion, that is, both go beyond the data, but in the case of unhealthy emotion it is the *nature of the belief* that determines whether the emotion is healthy. For the emotion to be unhealthy, the belief has to be personally relevant and irrational. Careful analysis of a table in Dryden and Branch (2008), however, suggests that the reason the beliefs are irrational is because they are non-objective, or held in a black and white way rather than being treated as propositions or hypotheses. In fact, as the authors say, 'the type of thinking your client engages in as a result of holding rational beliefs is, in general, more realistic and more balanced than the type of thinking she engages in as a result of holding irrational beliefs which tend to be skewed and distorted' (p. 68). Thus the relationship between process of thinking (inference) and belief is bi-directional, with the potential to increment in either a negative or a positive direction.

Schema therapy

Schema therapy is a form of cognitive therapy developed by Jeffrey Young. It shares a number of important propositions with Beck's cognitive therapy, but differs in some important ways. The definitive text is *Schema Therapy* (Young, Klosko & Weishaar, 2003). Schema therapy was developed especially to assist people with characterological problems. Such people either needed more

therapy after aspects of their problems were treated with CT, did not have marked symptomatic disturbance or found it difficult to access or change their thoughts, especially non-surface thoughts, in conventional CT. Traditional CT can be done in a fairly psycho-educational way with people suffering from depressive disorders or anxiety disorders whereas schema therapy may be better for people with complex mixtures of disorders or personality disorders. Schema therapy places a much greater emphasis than traditional cognitive therapy on exploring the childhood and adolescent origins of psychological problems, uses more experiential techniques and places more emphasis on the therapist–patient relationship.

Schema therapy was developed out of cognitive therapy. In Beck's theory schemas are '*Relatively enduring internal structures of stored generic or prototypical features of stimuli, ideas, or experience that are used to organise new information in a meaningful way thereby determining how phenomena are perceived and conceptualised*' (Clark, Beck & Alford, 1999, p. 79; emphasis original). Young sees schemas as broad, pervasive themes or patterns, comprised of memories, emotions, cognitions and bodily sensations, regarding oneself and one's relationships with others. They are developed during childhood or adolescence, elaborated throughout one's lifetime, and can be dysfunctional to a significant degree. Young has previously used the term 'early maladaptive schemas', thereby emphasising that the phenomenon commences in childhood, and that some schemas are emotionally and/or behaviourally counterproductive.

Schemas are a hypothetical construct used to explain particular aspects of cognitive processing and resulting emotion and behaviour. As such they are value neutral, and can be emotionally positive or negative, and behaviourally productive or counterproductive, to varying degrees. Since both Beck's and Young's Theories are concerned with psychopathology, they deal with the schemas that are associated with psychopathology. In this section I will continue to use the earlier term 'early maladaptive schema' (EMS) to acknowledge the idea that schemas are a general phenomenon and only some of them are maladaptive and derived from toxic experiences.

Early maladaptive schemas are caused by noxious experiences that are repeated regularly throughout childhood and adolescence. Schemas formed within a family may reflect the atmosphere of the family quite accurately, and may be productive within that context, but they may become counterproductive once the individual starts to spend more time outside the family, because the contingencies in the outside world are different from those within the family. A family may be a very harsh environment or it may be extremely indulgent, whereas (at least in Western cultures) the contingencies in the outside world are likely to be less extreme.

Alternately the schema may be the result of a *misinterpretation* of information available in childhood. For example a person might articulate his schema as 'my father was never there for me' when in fact every week the father drove for an hour to take the person to a nearby town and sat in the car for two hours while the young person went to the scout meeting.

Young acknowledges that emotional temperament makes some contribution to the development of EMSs and believes that four types of early life experiences are important in the formation of EMSs: toxic frustration of needs, traumatisation or victimisation, too much of a good thing, and selective internalisation or identification with significant others. Needs, for Young, include secure attachments to others; autonomy, competence and a sense of identity; freedom to express valid needs and emotions; spontaneity and play; realistic limits and self control. He has also identified a number of specific EMSs which he has collected into the domains of disconnection/rejection, impaired autonomy and performance, impaired limits, other directedness, over-vigilance and inhibition.

Schemas have different levels of severity and pervasiveness. The nature, severity and pervasiveness of an EMS is a result of the interaction between the child's temperament, their developmental experiences, and their interpretation of those experiences. Schemas can also be either conditional or unconditional.

Once EMSs have been acquired they are resistant to change. Young and colleagues (2003, p. 30) say that schemas are perpetuated through three primary mechanisms: cognitive distortions, self-defeating life patterns and schema coping styles. Cognitive distortions (or logical errors) lead to apprehending information in the world that is consistent with the schema. Sometimes the schema leads to behaviour that causes the person's experience to conform to the schema. For example, seeing the world as harsh and punitive leads to a paranoid attitude that causes the world to *be* harsh and punitive. A self-defeating life pattern is essentially replication of the environment that created the schema, or development of an environment that does not challenge the schema, but which still results in misery and/or counterproductive behaviour. Maladaptive coping styles are category labels for kinds of behaviour, and are based on the three basic responses to threat: fight, flight or freeze. Young characterises these as overcompensation, avoidance and surrender. Overcompensation is when the person operates as if the reverse of schema is true, such as behaving in a very entitled way when one really has poor self-esteem. Using the avoidance coping style, the person tries to make sure EMSs are not activated by avoiding possible triggers, such as tasks that involve high performance. When a person uses the surrender coping style they behave as if the schema is true, so a person who thinks they are worthless could choose to live the lifestyle of the most disadvantaged in the community.

Schemas are activated, probably, by activation of memories stored in the amygdala. Specific schemas are activated because of similarity between the precipitating event, and events that were critical in forming the schema. There are different degrees of activation of schemas, probably depending on the degree of similarity to the developmental conditions, and on a range of environmental and organismic variables. Activation of the schema leads to the behaviour, which is can be counterproductive and leads to perpetuation of the schema as already described. Young distinguishes between coping *responses*, which are the specific behaviours such as excessive drinking of beer, and coping *styles*, which are the tendencies to use behaviour that is avoidant, overcompensatory or schema compliant.

In Young's theory, behaviours are responses to schemas, that is, not part of schemas. Young is very clear that 'Behavior is not part of the schema, it is part of the coping response' (Young et al., 2003, p. 32), which begs the question of where the behavioural tendency is stored. Part of his reasoning is that the person has three kinds of behaviours they can perform in any situation that evokes an EMS: overcompensating behaviour, avoidance behaviour and surrender behaviour. For Young, because there are the three alternative kinds of responses, behaviours cannot be attached to or part of a schema. This is somewhat different from my view, which is set out in Chapter 7.

Schema therapy includes the concept of modes. Young (in Young et al., 2003, p. 49) states that he developed the concept to 'differentiate between schemas and coping styles as *traits* (enduring, consistent patterns) and schemas and coping styles as *states* (shifting patterns of activation and deactivation)'. A person will have many more schemas than are activated at a point in time. A mode is collection of schemas that are activated (to lesser or greater degrees) at a point in time together with the associated emotions and behaviour. Young describes ten modes: vulnerable child, angry child, impulsive, undisciplined child, happy child; compliant surrenderer, detached protector, overcompensator; punitive parent, demanding parent; and healthy adult. The transition from one mode to another is called 'flipping'.

Treatment in schema therapy is sometimes rapid and sometimes very long term. The first phase is assessment and education. In this phase the patient and the therapist come to an understanding of the schema configuration and associated typical behaviour for the person. The second phase is the change phase. The first part of the change phase is very like standard cognitive therapy and involves analysing and disputing the cognitive content of the schema. Other parts of the change phase involve changing other aspects of the schema. This may be by incorporating new information into

the schema by experiential or imagery techniques or exercises. The person who thought his father was never there for him could rehearse his father patiently waiting outside the Scout Hall, for instance. New more productive behaviours may also be developed and rehearsed.

Thus Young's view of schemas differs from Beck's in a number of significant ways. Young's view is more comprehensive in that it includes emotional and associative elements and includes perpetuating factors. Non propositional factors such as emotions and memory are integrated into the schema. Young sees the differences between his and Beck's view as being subtle and of emphasis rather than fundamentals. He sees Beck's view of concept of the schema as being a structure, and that the content is the 'core belief'. He states (Young et al., 2003, p. 49) that his definition of schemas *includes* the structure and content of Beck's concept and that schema activation incorporates affective, motivational and behavioural components.

A major difference for the two, according to Young, is the concept of mode. He sees Beck's ideas of modes as being more like his view of schemas. He sees the more subtle differences as being schema therapy's greater emphasis on coping styles and core needs and developmental processes.

There are also differences in the treatment approaches. In schema therapy therapists begin with schemas and then link these to cognitions and then proceed as described above. In CT the therapist starts with automatic thoughts and works towards schemas if necessary. When cognitive therapists work on schemas they do not usually go beyond the propositional techniques, whereas Young advocates the use of experiential and emotional techniques.

Young acknowledges similarities with CT (Young et al., 2003, pp. 47–53). Both therapies:

- emphasise collaboration, including sharing the case conceptualisation with the client
- encourage the therapist to play an active role in directing sessions and the course of treatment
- encourage empiricism, that is, they encourage patients to modify their cognitions, including schemas, to be 'more in line with 'reality' or consistent with empirical evidence derived from the patient's life
- encourage keeping track of cognitions and behavioural rehearsal
- teach patients strategies for altering automatic thoughts, underlying assumptions, cognitive distortions and core beliefs
- emphasise the importance of educating the patient about the model
- teach specific practical strategies for handling life events outside the session in an adaptive manner.

Similarities amongst the three main schools of cognitive therapy

Probably the important thing for this book is that all three of REBT, CT and SFT involve:

- dysfunctional cognitive content
- dysfunctional cognitive process
- associated counterproductive behaviour
- recurrent themes and patterns that can be identified in the content, process, and behaviour. These themes and patterns involve lack of logic, and negative content about the self, the world and interpersonal matters.

In Chapters 5 and 6 we will compare these common aspects of the cognitive therapies with the teaching of Jesus, but first it is appropriate to understand the context of Jesus' teaching and then the style and content of that teaching. That will be done in Chapters 3 and 4.