

# Cognitive Behaviour Therapy

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## ABSTRACT

*The article briefly discusses the development of cognitive behaviour therapy (CBT), and makes mention of the important contributions made by South Africans in this regard. An outline of the CBT approach is provided. There follows an illustration of this as applied to the treatment of depression. The effectiveness of CBT is substantiated by numerous studies. Further research should be done in the local context to in an endeavour to enhance its effectiveness in the previously disadvantaged community. South Africans should once again contribute to the development of this effective therapy, and continue the pioneering work done by their countrymen.*

**Keywords:** *Cognitive, Behaviour, Therapy*

## Introduction

Cognitive behaviour therapy (CBT) developed out of the work of the early behaviour theorists – Watson<sup>1</sup>, Skinner, Mowrer<sup>2</sup>, Dollard & Miller<sup>3</sup>. Watson rejected introspection and this had a significant influence on early theorists who focussed only on the role of external variables and stimuli. Successive researchers broadened their investigation to include the importance of cognitive mediating factors in behaviour. The work of Meichenbaum<sup>4</sup>, and Beck<sup>5,6</sup> was particularly important in this regard.

South Africans were influential in the development of behaviour therapy. Joseph Wolpe, Jack Rachman and Arnold Lazarus contributed hugely in this direction.

For many years, however, research and training in cognitive behaviour therapy was minimal in this country, the reasons for which are beyond the scope of this article.

The demonstrated efficacy, and the substantial research indicating that CBT is the optimal treatment for a number of conditions has rekindled interest in the training of therapists in this treatment approach

The present article will present an outline of the cognitive behaviour therapy approach, and a brief example of its use in depression.

## Cognitive Behaviour Therapy

### Definition

It is a form of therapy where the patient is helped to recognise patterns of distorted thinking and dysfunctional behaviour. Sys-

tematic discussion and carefully structured behavioural assignments are then used to help patients evaluate and modify their distorted thoughts and dysfunctional behaviours

It can be seen from this definition that there has been a marked shift from the stimulus – response approach of the early theorists. CBT can be understood as: stimulus → interpretation → response.

The meaning or interpretation the individual attaches to his perceptions and experiences is paramount in determining his response.

### General Principles of CBT

1. Concepts are expressed in operational terms
2. There is an empirical validation of treatment, with a variety of objective and reliable measures
3. Much treatment is based on the here and now.
4. The main goal of therapy is to help patients bring about desired changes in their lives
5. Problem solving is an important, integral part of treatment
6. All aspects of the therapy are made explicit to the patient, e.g. they are taught the laws of learning
7. The therapist and patient work together in a collaborative relationship, in which they together plan strategies to deal with clearly identified problems.
8. The therapy is time limited
9. The therapy has explicitly agreed goals
10. Homework is an essential part of therapy.<sup>7</sup>

### Cognitive Behavioural Assessment

A substantial proportion of the therapy lies in the assessment and behavioural analysis of the presenting problems. Most of the assessment is in the initial sessions, but assessment continues

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throughout treatment, and the patient's response to and cognitions about the intervention provide further material for investigation and intervention.

The central principle in the problem formulation is that the way in which an individual behaves is determined by immediate situations and the individual's interpretation of them.

Enquiry is made as to what the person is doing overtly and covertly that they would like to change. It is essential to cover four areas behavioural, cognitive, emotional and physiological. The consequences of the behaviour are explored in detail, as these reveal what may maintain the behaviour in the short or long term (which may appear contradictory) and can suggest possible secondary gain, which would interfere with the progress of treatment.

The major part of the assessment is in the behavioural interview, and this is supplemented by information collected and recorded by the patient after the interview.

An overview of the behavioural assessment can be found in the chapter by Kirk in Hawton.<sup>7</sup>

The therapy can be seen as a single case experiment.

**CBT of Depression**

Beck<sup>5</sup> initially described the use of cognitive therapy with depression. Subsequently the principles were extended to the treatment of generalised anxiety disorder and panic, phobias, and obsessive compulsive disorder.

He proposed that negative thinking that is so prominent in depression is not just a symptom, but has a central role in the maintenance of depression. He regarded it as a useful point of intervention in the cycle of negative thoughts and symptoms. A common misconception of this theory is that he maintained that negative thoughts cause depression. He does not implicate cognitions in causality.

A review of the cognitive model and treatment for depression will provide an introduction to the CBT method ( Figure1).

Early experience leads people to form assumptions or schema about themselves and the world. These are subsequently used to

organise perception and govern and evaluate behaviour e.g., "If someone thinks badly of me, I cannot be happy" "I must do well at everything I undertake

Problems arise when "CRITICAL INCIDENTS" occur which mesh with the person's own system of beliefs, e.g. the belief that personal worth depends entirely on success, could lead to depression in the face of failure. Dysfunctional assumptions are then activated and these produce an upsurge of "negative automatic thoughts". Negative, in that they are associated with unpleasant emotion and automatic because they pop up into people's heads rather than being the result of any deliberate reasoning process.

They may be interpretations of current experiences predictions about future events, or recollections of past events, which lead on to symptoms of depression:

- BEHAVIOURAL - lowered activity, withdrawal
- MOTIVATIONAL - loss of interest, inertia
- EMOTIONAL - anxiety, guilt
- COGNITIVE - poor concentration, indecisiveness
- PHYSICAL - loss of appetite, sleep

The more depressed one becomes, the more depressing thoughts one has, the more they are believed, the more depressed one becomes...

The cognitive therapist breaks into the vicious cycle of thoughts, by teaching patients to question the negative automatic thoughts, and then to challenge the assumptions on which they are based.

Note that Beck says that there is a quantitative, rather than a qualitative difference in thoughts between those who are and who are not depressed. Depression exaggerates and intensifies processes present in all of us.

**Selection criteria for patients**

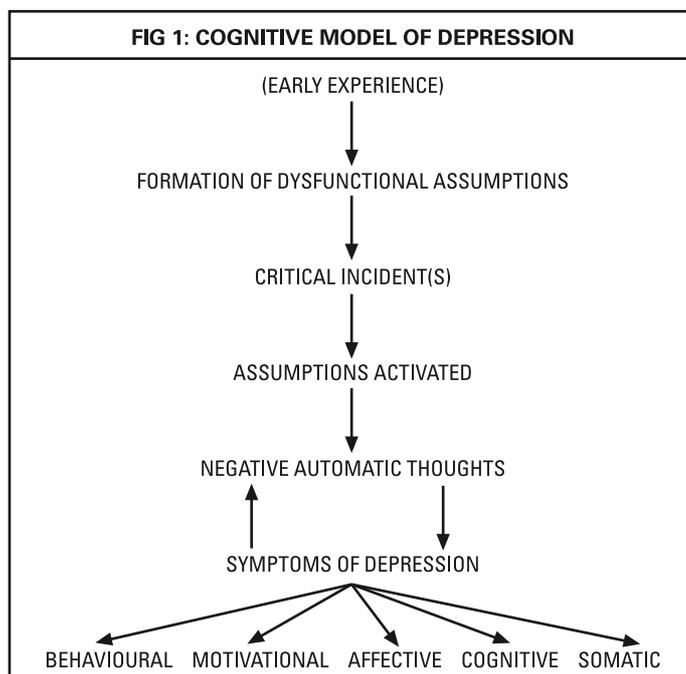
1. Major depression: Not suitable for psychotic depression. Initially, bi polar patients were also regarded as unsuitable but CBT has been adapted to deal with these patients and is useful in extending the well periods between cycles, and in helping patients to identify triggers.
2. "Endogenous" as well as exogenous cases.
3. It can be used in conjunction with medication
4. Severity: Beck Depression Inventory (BDI) scores less than 26.
5. Does patient report depressive cognitions? Is cognitive triad (negative view of self, of the present and of the future) present?
6. Acceptance of treatment rationale – model makes sense to the patient.
7. Can patient form an equal collaborative relationship?

**Behavioural Strategies**

The goal here is to maximise engagement in mood elevating activities, and these tasks are also used to test thoughts which block engagement in such activities. These can be divided into

**Monitoring Activities**

Monitor behaviour hour by hour, rating each behaviour on the amount of Pleasure and Mastery (sense of achievement) each activity brings. This provides hard data on the patient's level of activity, and can identify when and where difficulties may arise.



**Figure 2: DAILY RECORD OF DYSFUNCTIONAL THOUGHTS**

DATE	SITUATION	EMOTION	AUTOMATIC THOUGHTS	RATIONAL RESPONSE	OUTCOME
	Describe: 1. Actual event leading to unpleasant emotion or, 2. Stream of thoughts, day-dream, or recollection, leading to unpleasant emotion.	1. Specify sad/anxious/angry, etc. 2. Rate degree of emotion, 1-100	1. Write automatic thought(s) that preceded emotion(s) 2. Rate belief in automatic thought(s), 0-100%	1. Write rational response to automatic thought(s) 2. Rate belief in rational response, 0-100%	1. Rerate belief in automatic thought(s), 0-100% 2. Specify and rate subsequent emotions, 0-100%
				1. Where's my proof? 2. What alternatives are there? 3. What might someone else do or say in this situation? 4. What might I do or say to someone else in this situation?	

Explanation: When you experience an unpleasant emotion, note the situation that seemed to stimulate the emotion. (If the emotion occurred while you were thinking, daydreaming, etc., please note this.) Then note the automatic thought associated with the emotion. Record the degree to which you believe this thought: 0% = not at all; 100% = completely. In rating the degree of emotion: 1 = a trace; 100 = the most intense possible.

**Scheduling Activities**

Plan each day hour by hour

GOAL – increase activity, maximise pleasure/ mastery

The global mass of work is reduced to specific, and this increases the sense of control over one’s life.

**Graded Task Assignment**

Maximise the chance of success by breaking tasks into small, manageable steps, each of which is reinforced in its own right It redefines success realistically

**Cognitive Behavioural Strategies**

Most treatment sessions and homework are directed to teaching the patient to identify, question and test negative automatic thoughts .

Negative automatic thoughts (NATS) – distort experience, are habitual, automatic and involuntary; they may seem plausible and are triggered by multiple stimuli, including therapy.

The presence of NATS is signalled by a significant mood shift. The patient is taught that thinking precedes feeling in most cases and can also lead to an exacerbation of feelings. An extremely useful therapeutic tool is a Dysfunctional Thoughts Record (DTR) (Figure 2).

This is used by the patient to identify the situations under which the NATS occur, and what the NAT is. Patients are instructed to view thoughts as hypotheses, not facts and then to challenge or test these thoughts, to see if they can come up with a more realistic thought which will supplant the NAT. Re-evaluation of the NAT is then encouraged. The patient learns to become more aware of the negative automatic thoughts which mediate his emotional response.

Subsequently the patient is taught about the types of cognitive distortions which subtly alter the information we process.

Examples include:

*Overgeneralisation* - drawing a rule based on one instance of behaviour e.g “Everything I do, I mess up”

*Dichotomous reasoning* – seeing things in terms of absolutes, e.g. “either I am a success or a failure.”

*Arbitrary inference* – drawing a conclusion based on little or

no evidence, e.g.” no one will ever want to be with me”

A more complete list of these distortions may be found in the work of Beck<sup>5</sup>, Burns<sup>8</sup> and Greenberger & Padesky.<sup>9</sup>

Behavioural experiments also permit the modification of negative automatic thoughts. An example may be of putting new ideas to the test:

- i. Make a prediction - e.g.”If I tell my wife how bad I feel, she will be angry with me.”
- ii. Review existing evidence for/against the prediction.
- iii. Devise a experiment to test the validity of the prediction.
- iv. Maximise the chance of positive outcome, e.g. through role play.
- v. Note results: The results may be used to alter negative automatic thoughts.
- vi. Draw conclusions from the results.
- vii. Formulate a rule: “Don’t make assumptions about how other people will react to you; find out for yourself.”

Once the patient can consistently recognise and correct the negative automatic thoughts, the focus of the therapy shifts onto identifying the faulty assumptions or schema which may have predisposed the patient to developing their condition.

There are 3 central areas – achievement, control and acceptance.

These generalised rules are more difficult to identify – clues may be found in:

- i. themes which may have emerged in treatment e.g. preoccupation with rejection.
- ii persistent logical errors which are being made.
- iii global self evaluations e.g. “ I am childish, weak.”
- iv memories, family sayings e.g. “cowboys don’t cry.”
- v. high mood indicates assumptions are met, low they are violated e.g. delight at being liked – may suggest that one needs to be liked by all.

Once the assumptions or schema have been identified, they need to be challenged and more appropriate schema need to be adopted, as this would significantly reduce the chance of relapse. This is done through verbal challenge, and involves the deliberate at-

tempt to generate a more reasonable and realistic alternative.

Young<sup>10</sup> has identified schemas he calls early maladaptive schemas (EMS), which consist of 16 schemas in 6 different domains. Practitioners would do well to acquaint themselves with his work as this would facilitate an identification of problematic schemas.

Towards the end of the therapeutic process, the assignments given focus on the fears and NATS surrounding the termination of therapy and the ability to cope on one's own. A summary of techniques which were found useful is kept handy (blueprint)

CBT for depression has demonstrated its efficacy in many research studies,<sup>11</sup> and has been shown to be at least as effective in reducing depression as antidepressants. Studies also suggest that CBT therapy may be more effective in preventing relapse than antidepressant drugs.<sup>12,13</sup>

Therapists would serve themselves and their clients well by becoming proficient in CBT techniques.

More local research into CBT and its effectiveness in previously disadvantaged populations needs to be conducted. South Africa is regarded as one of the birthplaces of behaviour therapy, and we should endeavour through these efforts to show that we have continued to grow, and make a further contribution to the enhancement of therapy.

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# Psychotherapy: no place for purists

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Kevin Bolon's article, Cognitive Behaviour Therapy (CBT), rightly credits the significant influence in the development of behaviour therapy to South Africans: Joseph Wolpe, Jack Rachman and Arnold Lazarus. Bolon points out that it is important that research and training in CBT in South Africa should be encouraged, developed and more influential than it has been. He gives a clear and competent account of CBT and its application to depression. His descriptions of principles, practical applications and examples of tasks and records, are extremely useful and make CBT readily accessible to the reader.

Although Bolon alludes to the application of CBT to the South African context he does not, unfortunately, pursue this thinking. Take the HIV/AIDS crisis for example. Behavioural programmes designed to remind less educated and/or rurally placed HIV positive AIDS patients to take their medications via regular mobile phone prompts, could be useful in communities with limited access to clinics but some access to mobile phones. Similarly, cognitive behaviour strategies to address negative automatic thoughts (NATS) with regard to avoidance, irrational fears and suspicions regarding AIDS/HIV transmission, or the value of anti-retrovirals, could be very powerful in a country besieged by confusion, inertia and misunderstanding in its current health policies.

Surprisingly, Bolon fails to address any of the current debates on the applicability of CBT to certain conditions, disorders or pathologies. It is very clear that CBT is highly effective in the treatment of a number of conditions, such as panic disorder, generalized anxiety disorder (GAD), obsessive compulsive disorder (OCD) and mild depression<sup>1,2,3,4</sup>. Significantly however, many of these conditions demonstrate a more effective outcome when treated concomitantly with psychopharmacological agents, such as SSRI's. However, not all psychological and/or psychiatric conditions are suited to CBT, nor are all patients with similar conditions amenable to CBT. Personality disorders have been shown to have a better outcome with modified psychodynamic approaches<sup>7,8,9</sup>.

Certain behavioural difficulties are better dealt with through systemic approaches where family or marital functioning is compounding or maintaining psychopathology<sup>10,11</sup>. Equally, children with anxiety disorders or OCD often do not comply with cognitive behavioural programmes as their symptoms are egosyntonic and only of concern to their parents. Without the

underlying motivation to change their behaviour, cognitive behavioural programmes are of little consequence to these children. Approaches that focus on personality style, defensiveness and the centrality of the therapeutic alliance are more appropriate in these instances. The advantage of the psychodynamic approach is its attention to the role of personality factors in illness. Characterological resistance to treatment frequently jettisons the medication regime or the cognitive behavioural treatment programme envisioned for certain patients<sup>9</sup>. Many symptoms are embedded in character structure and a psychodynamic approach would recognise that treatment of the symptoms without first addressing the character structure would not be feasible. An example would be borderline personality disordered patients who lack boundaries, cannot deal with structure and are unable to contain overwhelming anxiety when faced with real or imagined abandonment. Such patients are unable to exercise the discipline required to follow through a structured cognitive behaviour therapy programme. Checklists are not filled in, appointments are missed and obtaining a baseline of behaviour, trying to monitor activities or record thoughts is all but impossible.

Similarly, a common problem in treating depression in personality disorders is differentiating characterological depression typical of the borderline personality from major depressive disorder. The latter responds well to CBT and/or psychopharmacology. However, characterologically disordered patients may describe chronic feelings of boredom, emptiness and loneliness as, "depression", but they lack the vegetative signs of Axis I major depression<sup>12</sup>. In a study of 50 depressed patients, 21 of whom had borderline personality disorder, Rogers, Widiger and Krupp,<sup>13</sup> corroborated the finding that depression associated with borderline personality disorder is distinct from that found in non borderline patients. Gunderson and Phillips<sup>14</sup> have suggested a differential diagnoses of major depression and the characterological depression of borderline personality disorder. The latter would include reports of loneliness, emptiness, anger, neediness, repeated suicidal gestures, demanding hostile dependent relationships and concern with interpersonal loss and separation. Major depressive disorder would include the vegetative features of an Axis I diagnosis, guilt feelings, remorse, withdrawal, agitation, suicidality, concern with defeat and/or failure and a history of relatively stable relationships. Caregiving or treatment is usually welcome in these patients. Shared characteristics would include depressed mood, feelings of worthlessness or hopelessness and fragile self-esteem. Interestingly, SSRI's appear to be useful even in borderline patients without comorbid affective disorders giving rise to some debate that they work at the level of tempera-

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ment.<sup>9,15</sup> Nevertheless, in the case of personality disorders, psychopharmacology although not curative, often decreases agitation and levels of anger,<sup>16,17</sup> rendering these patients more accessible to individual psychotherapy. Typically, medical aid societies do not support long-term psychodynamic therapy interventions considering them prohibitively expensive. Gabbard<sup>18,19</sup> reports a growing body of literature indicating that extended psychotherapy of a year or more, is not only successful in making substantial improvements in borderline patients but is also cost effective. Among the improvements noted in one year of twice weekly psychodynamic therapy were statistically significant decreases in: -

- 1) time spend away from work,
- 2) number of visits to medical professionals dropped to one seventh of pre-treatment rates,
- 3) number of self harm episodes declined to one fourth of pre-treatment rates,
- 4) number of hospital admissions decreased by 59%, and
- 5) time spend as an inpatient dropped by half.

More importantly these results were sustained at a 5-year follow-up<sup>20</sup>. Clearly, when dealing with personality disorders there is no instant cure, but these studies demonstrate that extended psychodynamic therapy may be cost effective in the long run.

I do not wish to advocate that psychodynamic therapy is superior to CBT, or that systemic therapies, gestalt therapies or any of the humanistic person centred psychotherapies are particularly superior in their results or application. Instead I wish to take an integrationist position and argue that certain types of psychotherapy are suited to specific disorders, relationship problems or behaviour difficulties and that once personality difficulties are evident, these will require direct management, if any treatment modality is to be effective. CBT is particularly favoured in psychiatry because its results are easy to measure and its focus and goals are well defined. Psychotherapy schools which attempt to address personality difficulties, problems of alienation, emptiness and existential misery are more diffuse, more difficult to define and less amenable to measurement. This should not render their application less valuable or notable.

The difficulty in devising the right form of psychotherapy for the right disorder or correct personality structure has its roots in the theoretical foundations of psychology. There is a debate that plagues the social sciences and psychology in particular, from which the natural sciences is comparatively unfettered. The debate entails the extent to which psychologists should ideologically position themselves as theoretical purists. Many psychologists, excluding Bolon, present themselves as fervent psychoanalysts, cognitive behaviour therapists or systemic thinkers. They reject the view that different theories can be used to understand different patients or pathologies.

To clarify this debate we must appreciate that despite internal theoretical conflicts, progress in the natural sciences became sequential, as theories were challenged, tested and developed. The social sciences have been besieged by debate and parallel developmental paths. The natural sciences for the most part, operate within the principles of a unitary or primary scientific paradigm. This paradigm may, however, in time, be challenged and displaced by a new, more effective paradigm. Parallel theories or schools of thought exist until

one dominates and becomes the primary paradigm. Thomas Kuhn<sup>21</sup> traced the evolution of scientific disciplines and found that most theories in the natural sciences began in what he called a pre-paradigmatic period. During a pre-paradigmatic period, practitioners of a discipline are divided into a number of competing schools, each of which approaches the same subject matter differently. During the pre paradigmatic period each competing school claims that its way is the most accurate. This stage continues until a major scientific breakthrough occurs that makes most of the remaining schools obsolete. A dominant paradigm then pervades the particular science. Famous examples of scientific revolutions which led to new paradigms, include, Copernicus' assertion that the sun, rather than the earth, was the centre of the universe, or Galileo's assertion that the earth was not only round but revolved around the sun. Later, one of the most significant revolutions was the displacement of aspects of the Newtonian paradigm of physics by Einstein's paradigm of relativity.

An example of human behaviour that has been subject to rival explanation is that of epilepsy. For some, epilepsy was considered evidence of demon possession, for others it was a calling to religious duty. Strongly some these explanations continue to be supported by a minority even today. As medicine developed as a discipline, epilepsy was explained by more scientific principles. Epilepsy has endured psychoanalytic explanation, become the focus of early psychiatric explanations and now finds its new home in neurology. Each shift occurred as new theoretical explanations challenged old beliefs about the nature and aetiology of epilepsy.

Psychology, including the various competing schools of psychotherapy, is currently in the pre paradigmatic phase. This is because psychology is relatively young as a social science and because the theories of psychotherapy attempt to explain and predict phenomena that are highly complex. There are a number of competing schools and models viz., psychoanalysis, cognitive behaviour therapy, systemic psychotherapy, humanistic/existential psychotherapy, and a number of postmodern schools. Each holds its own position to be valid. Each of these theoretical schools makes different assumptions about human nature, personality, how it functions and what methods of psychotherapy it recommends to effect change.

Psychodynamic psychotherapy is an approach to diagnosis and treatment characterized by a way of thinking about both patient and clinician that includes an attempt to understand unconscious conflict, deficits and distortions of perceptions, memories and feelings, and the quality of relationships with significant others. The patients subjective experiences are valued and a great deal of importance is placed on the patient's internal world, i.e. fantasies, dreams, fears, impulses, wishes, self-images, defences and psychological reactions to symptoms.

Behaviour and cognitive behavioural approaches include a variety of techniques, which bring about observable and measurable changes in human behaviour. The theoretical assumption implied in behaviour therapy is that the image of the person is reflected through their behaviour. Well-being is assessed through observation of behaviour, self-control and mastery of the environment, allowing patients to achieve their goals. All behaviour, normal or pathological, is learned, usually through classical or openant conditioning. Symptoms are viewed as discrete pieces of behaviour, which have arisen through faulty

learning, just as normal behaviour can be modified, so maladaptive behaviour can be altered by means of unlearning. Behaviour therapy aims to be objective and focuses on overt behaviour and the environment rather than subjective experiences or internal forces underlying the problem. It emphasizes an empirical approach and insists that human behaviour is quantifiable. This approach is particularly popular in positivistic research because behaviours can be measured, quantified and statistically manipulated, rendering findings that are neat, uncomplicated but often dry and meaningless. Cognitive behaviour therapy grew out of a dissatisfaction with the neglect of the traditional behaviour therapy school, of the mind or "internal mediating concepts"<sup>22,23,24</sup>. The cognitive behavioural approaches emphasise the role of cognitions, thoughts, beliefs, irrational ideas in the production or maintenance of abnormal behaviour. Behaviour and emotions are viewed as resulting from cognitive processes. Maladaptive behaviours and emotions are changed by correcting dysfunctional beliefs. The therapist's function is to uncover dysfunctional cognitions and help the patient develop new cognitive and behavioural patterns.

The humanistic psychotherapy approach as developed by Carl Rogers<sup>25</sup> person-centred approach was considered radical because it was counter to the directive approaches that dominated at the time. In this approach self-actualisation is emphasized. The self is defined as an individual's dynamic organization of concepts, values, goals and ideals, which determine the ways in which he/she behave. The concept of the self is a learned attribute, a progressive concept starting from birth and differentiating steadily through childhood to adulthood. The development of the self-concept is influenced by an individual's need for positive regard or approval from his/her caregivers. The developing child learns an internalized sense of worth based on his/her perception of the regard received from significant others. One's self regard comes to depend on the conditions of worth one has learned through interactions with significant others. When a person's concept of self is congruent with his/her perceived experience, he/she is acting in accordance with their values, ideals and they are healthily adjusted. A person not acting in accordance with their self-concept is incongruent. The principle counselling implication of this theory of congruence is to help the clients face courageously the incongruence between awareness and experience. Although the self-actualising tendency is postulated as being biologically determined, the direction of the growth tendencies is assumed to be environmentally determined by parents, peers, teachers and other significant people. In person centred therapy the counselling relationship is considered the central means for promoting health and growth. The relationship aims to generate empathy, positive regard and authenticity on the part of the therapist. This emphatic understanding is believed to have a curative effect on the patient.

Unlike psychodynamic, cognitive behavioural or humanistic theories, systems theories and therapies emphasize a more contextual way of viewing symptoms or behaviours. Systems theories tend to operate on less individualistic assumptions than other psychotherapies. Systemic theories consider the role of the individual as part of a larger interpersonal system. Psychotherapy from this perspective pays less attention to intrapsychic dynamics and instead focuses on the transactions between people in shaping behaviour. Systems theory is prima-

rily a way of conceptualising therapy, not a question of the number of people in the therapist's office. A systems therapist might see an individual in the session but think about this person's difficulties, systemically. The central concepts in systems therapy are that the individual is embedded within a larger relational context. Any part of the system is best understood by examining his/her position in the system. Transactional patterns in the system are involved in shaping the behaviour of individuals within the system. Dysfunctional behaviour is related to recursive patterns within the system. Therapists uncover the systems ability to define roles, solve problems, express emotion, adjust to change, manage power coalitions or maintain boundaries. A family system, for example, will be assessed for its functionality in terms of these criteria and the therapy will focus on issues such as restoring parental roles, adjusting to family developmental changes such as the birth of a new sibling, and so on.

Each of these four different theoretical schools of psychotherapy, viz. psychodynamic, humanistic/existential, cognitive behavioural and systemic have contributed to an increased understanding of human nature, behaviour, pathology as well as provided useful therapeutic techniques. More recently we have seen the rise of what could be regarded as a fifth theoretical school in the social sciences, viz., post modernism, which has spawned an influence on psychotherapy<sup>26,27,28</sup>. While the period of modernity accepted a grand theory of explanation of phenomena, the postmodern approach advocates that all narrative or personal explanations of phenomena are equally valid. The post modernists would argue that there is no ultimate history, no specific scientific explanation or fundamental truth. All explanations are equally valid given individual inter-subjectivity and personal perspective. My own view is that postmodern approaches applied to the arts, literature or music are perfectly reasonable, even interesting. Why should there be one interpretation of Shakespeare, Bach or T.S. Elliot. However, such an approach to an applied field such as psychology or psychotherapy is not valid or even ethical. In psychology or psychiatry there are absolutes and basic truths do exist. Psychotic patients are not better off living in the streets and starving. Child abuse is not a question of subjective interpretation.

While purists cling to their individual schools of psychotherapy and emphasize their importance to the exclusion of other theories, integrationists such as myself, argue for the appropriate and effective application of methodologies drawn from different theoretical schools for different disorders, difficulties or problems. Because psychology remains in the pre-paradigmatic stage of scientific development, it is clear that the different theoretical schools are not all equally effective in all cases of dysfunction or pathology. It is also evident that contemporary application of the different approaches are demonstrating overlap and many schools of psychotherapy have concepts and techniques in common. Cognitive behaviour therapy has adopted a "mind" and focuses on irrational thoughts, usually the domain of psychodynamic therapists. Psychodynamic therapists have been forced to include the external world in their theories, as evident in self-psychology and the integration of attachment theory.

Clinical research and case study publications suggest that different therapeutic models are suited to different pathological presentations. For example, systemic approaches are ef-

fective for marital difficulties and family difficulties caused by dysfunctional interpersonal behaviours. Behaviour therapy in conjunction with psychopharmacology has been highly successful in treating obsessive-compulsive disorders and specific phobias. Cognitive behaviour therapy in conjunction with psychopharmacology has proved effective with anxiety disorders, social phobias and some mood disorders. Contemporary psychodynamic therapy<sup>29</sup> has demonstrated success in treating certain personality disorders. In sum, careful assessment of the patient is necessary for appropriate selection of the nature and type of psychotherapy necessary for specific problems or psychiatric disturbance.

In the absence of a primary psychotherapy paradigm, the discipline of psychology has provided (albeit by default) clinicians with a variety of choices. A good psychotherapist needs to consider, despite any primary theoretical allegiances, the best means to treat patients. Accordingly, a psychotherapist has two choices, theoretical integration or referral. Unfortunately there are those psychologists who still hold on to the unconscious fantasy that psychology is an art. It is a science, pre-paradigmatic perhaps, but growing.

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# Response

Kevin Bolon

The article was intended as an introduction to Cognitive Behavior Therapy, and the treatment of depression was used to illustrate some of the salient characteristics of the CBT approach.

Reference was made to the important role of South Africans in the development of behaviour therapy and it was pointed out that this impetus was not sustained, nor has CBT received equal emphasis to other forms of therapy at most universities.

Cora Smith is correct in noting that there was not a development of the benefits of broader application of CBT to the South African context. Numerous examples could have been given, and undoubtedly CBT would be particularly beneficial in the management of various chronic illness conditions - in the case of practical strategies and in identifying and correcting numerous negative automatic thoughts surrounding these illnesses from the life threatening such as AIDS/HIV to the incapacitating, such as Chronic Fatigue Syndrome.

Smith is also correct in stating that there was no addressing of any the current debates on the applicability of CBT to certain conditions, disorders or pathologies.

The article was intended as a practical introduction to CBT, using the treatment of depression as an example. In both the above instances, to address these issues was beyond the scope of the article, and indeed a separate detailed article would be necessitated to do justice to these points.

Smith points out that CBT is highly effective in the treatment of a number of conditions, such as panic disorder, generalized anxiety disorder, obsessive compulsive disorder and depression. This effectiveness has been demonstrated across numerous studies. The efficacy of CBT is enhanced when there is a concomitant use of medication. Both medication and CBT used independently are effective in facilitating an improvement in functioning in these conditions, and it is therefore unsurprising that there would be an additive effect. In many cases CBT may be used very effectively without medication, and it would appear to be particularly effective in minimizing the chances of relapse when used concurrently with medication, when the medication is withdrawn.

CBT is not an über-therapy which is suitable for all conditions, despite its demonstrated efficacy across a wide range of

conditions.

The presence of personality disorders does complicate the treatment of Axis I conditions. For example a comorbid schizotypal personality disorder substantially lowers the prognosis for the treatment of a patient with OCD.

There is a discussion of the types of conditions and patients who may not benefit from CBT. There is no one type of therapy which is appropriate for all clients or all conditions.

Smith makes some sound points in this regard. Others may be debated in a different forum. A significant disagreement, however, would be with her assertion that CBT would be inappropriate with borderline personality disordered patients. A modified form of CBT, called Dialectical Behaviour Therapy (Linehan, 1993) has been shown to significantly improve the functioning of these patients.<sup>1</sup>

It is correct that certain types of therapy are suited to specific disorders, relationship problems or behavior difficulties. CBT is not a panacea, nor was it presented as such in the article. The various psychotherapeutic approaches have their individual strengths and weaknesses and these should be highlighted in training. There is unfortunately, still an antipathy between some practitioners of the psychodynamic school and those of the behavioural persuasion which is outmoded and destructive. Smith provides a cogent and well reasoned perspective in her discussion of the contributions of the various schools of psychology and the integrationist position she holds, if adopted by the majority of practitioners would bode well for psychology, and for their clients.

Her conclusion, that "careful assessment of the patient is necessary for appropriate selection of the nature and type of psychotherapy necessary for specific problems or psychiatric disturbance" is lauded. The choices a therapist has as a result - theoretical integration or referral is logical and correct. A cautionary note is that many would be integrationists should take care to develop more than a superficial knowledge of the various interventions, and that the approach selected should feel congruent to them, or it would become therapy-by-numbers.

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