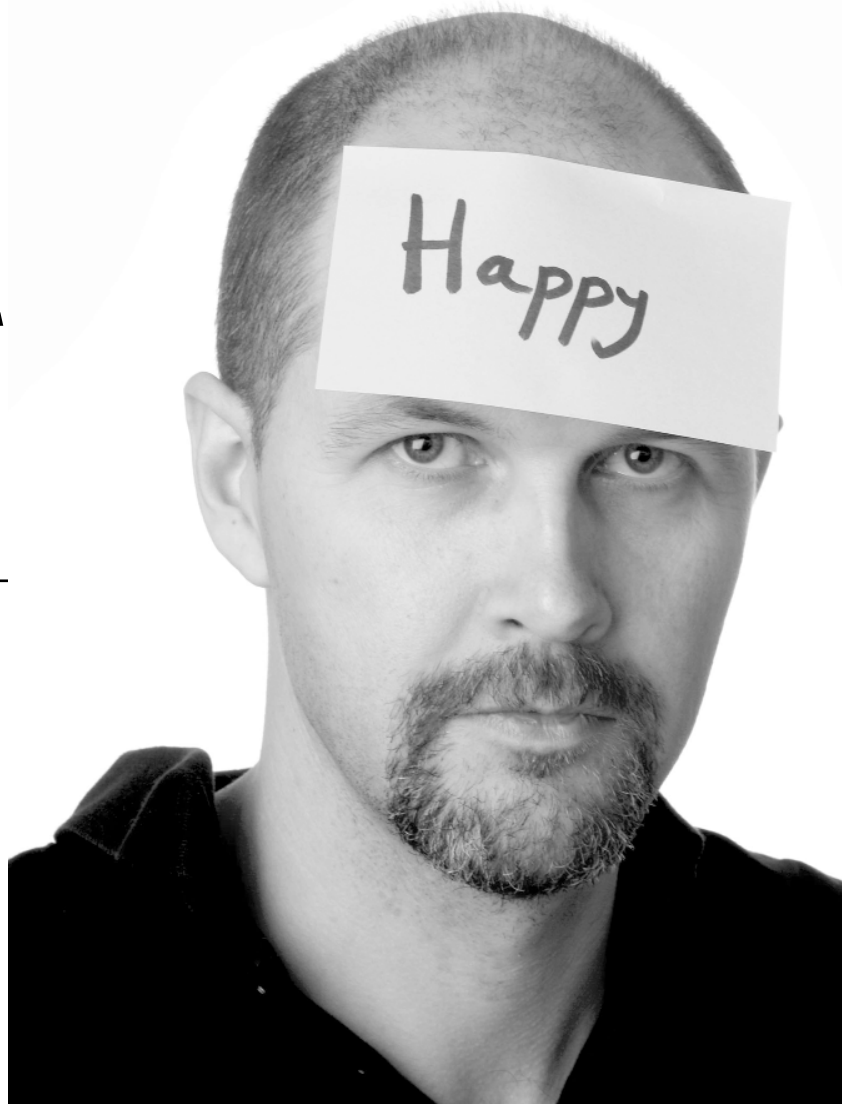
CBT in higher education



Following years working in the NHS, **Nicky Mitchell** has spent the last two years in higher education as a counsellor specialising in cognitive-behaviour therapy (CBT). Here she describes some of the principles of CBT, attempting to answer some of the criticisms it has received and setting out some of its uses in the higher education setting

Cognitive-behaviour therapy is relatively under-represented among counsellors in HE, the vast majority of CBT therapists being employed within the NHS. Following years in the NHS, I am now part of a team of HE counsellors trained in a number of approaches (psychodynamic, cognitive analytic, group analytic). This mix of approaches provides a helpful complement, giving the service opportunities to offer treatments of choice, where they exist, to clients.

Working in a team of therapists using different approaches creates many opportunities for us to learn from each other, and serves as a useful aid to prevent a fall into an unhelpful 'us and them' style of thinking. Talking to colleagues has demonstrated to me the similarities that some techniques and concepts used within other approaches have to those used in cognitive therapy, albeit using different language and sometimes with a different rationale. I hope in this article to tackle some of the criticisms of CBT and set out how I believe it may be useful within the higher education setting.

Basic CBT principles

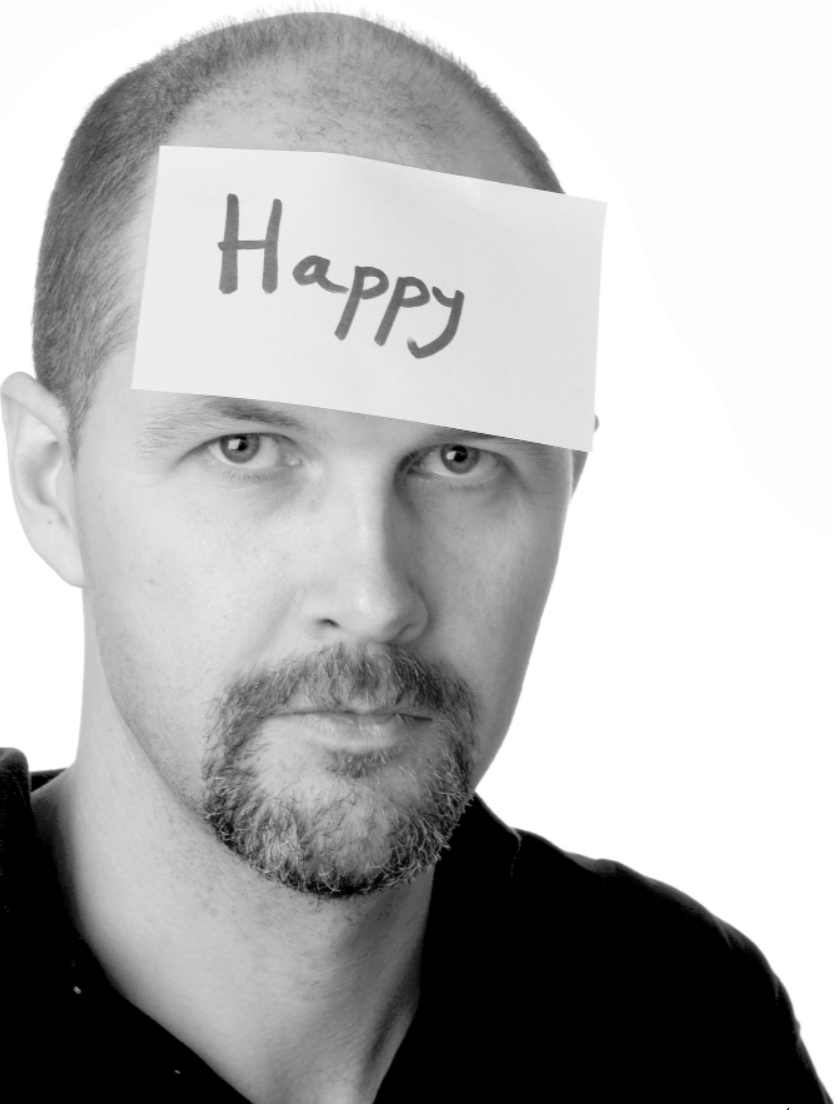
Importance of thinking

CBT emphasises the importance of thinking and of the meaning a person gives to a given situation in their response to that situation. Hearing a noise downstairs in the night, we may feel angry thinking 'that's my husband late back again, that's one time too many' and prepare for a row, whereas we might feel concerned if we think 'poor thing, he works too hard' and rush down to put the kettle on, or we might become fearful if we think 'it's too early for him, it's a burglar' and reach for the phone. In these instances our emotions have arisen more from our interpretation of the event than from the event itself.

CBT examines the role of the interaction between cognitions, emotions, biology and behaviour in the maintenance of psychological difficulties. As shown above, our interpretations often have an impact on how we behave, and so particular kinds of thinking may have an unhelpful impact on what we do. For example, if a person predicts that they will stumble over their words and be laughed at when preparing to make a presentation, they are likely to have symptoms of anxiety and may avoid the situation, never finding out what would actually have happened if they had stayed, and strengthening their belief that such a situation is socially dangerous. Likewise a depressed person may think 'no one will want to be around me in this state' which may perpetuate low mood and lead to avoidance of social situations and withdrawal from loved ones. This may serve to leave the person with an absence of pleasurable activities, which may lower mood further and strengthen belief in this thought, and so on. In such ways vicious cycles are created and maintained.

Testing evidence

In cognitive therapy these patterns may be explored and evaluated using 'Socratic questioning' – questions that explore and critically examine the client's ideas and experience. This provides the foundation for evaluating thinking and behaviour. Clients are helped to learn to scientifically test the evidence for distressing thoughts and to access alternatives. 'Thought records', in which



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negative thoughts are recorded and evidence for and against them generated, are frequently used to this end.

Another common technique in cognitive therapy that often follows thought records, and which may promote belief change more powerfully is the 'behavioural experiment'. This consists of a collaboratively designed activity that the client engages in with the intention of testing the validity of a particular belief. Such an activity may take place in the session or, more frequently, be agreed as a homework assignment. For example, a client who believes 'I must never show vulnerability to others or I will be rejected' might engage in an activity in which they tell a good friend about an area of difficulty. The client predicts the outcome of the experiment and notes what actually happens, together with what has been learned from the experiment.

A structured, collaborative approach

CBT is a structured approach. Each session is likely to follow a similar pattern: the counsellor asks for a brief mood check, then the client gives a brief review of their week, after which that session's agenda is agreed, followed by feedback about the previous session and the previous week's homework, after which the main agenda items are discussed and that week's homework is agreed. While this may appear rigid to some therapists, when used skilfully the various components of this structure follow on naturally from each other, with the aim to ensure that the therapy hour is used in the most helpful way.

CBT is also time limited, and is often comparatively short term. The approach is highly collaborative, emphasising the active nature of both client and counsellor in the client's progress, working together as a team (as opposed to the idea of the counsellor as an 'expert' who 'does' something useful 'to' the client). The more the client participates in the work (for example choosing particular experiments to carry out) the more useful it is likely to be for them and the more successfully they are likely to negotiate the task of becoming their own therapist.

Problem-solving goals

CBT is problem focused, so a client is likely to be asked in detail about the difficulties they are experiencing, including initial onset, examples of recent occurrences, how frequently they occur and when they are better or worse, the thoughts and behaviours associated with them, and so on, to enable hypotheses to be made about the particular factors maintaining them. CBT therapists will often draw up a 'problem list' with a client so that any inter-relationships between these can be explored and priorities for treatment can be made. This list also aims to reduce the potential for the client feeling overwhelmed by and hopeless about their difficulties, by producing a finite number of specific issues.

This practice often goes hand in hand with the practice of setting explicitly and collaboratively agreed goals. This checks that the counsellor and client are working on the same issues, ensures that the client's goals are realistic given the time frame of the counselling contract, and provides a concrete method of monitoring progress, as well as producing a focus on the future and the potential for things to improve. Specific goals are sought, so if a depressed client gave the general goal of not being depressed anymore, the counsellor might ask questions such as 'how would we know that you weren't depressed anymore; what might you be doing differently?' Goals are not set in stone and may be renegotiated during counselling as necessary.

Misconceptions about CBT

Although CBT is increasing in popularity it is still misunderstood by many professionals, and some commonly held views demonstrating this misunderstanding are highlighted below.

1 CBT fails to take clients' early lives into account

It is true that CBT places emphasis on the here-and-now, with most attention given to factors currently maintaining difficulties, especially in short-term work. However, cognitive therapists acknowledge the key contribution a person's life history makes to the development of their understanding of the world and in some cases to a vulnerability to later difficulties. This will be explored to a greater or lesser extent, according to the type and severity of the presenting problems, in order to aid an understanding of these difficulties. In recent years schema-focused cognitive therapy (Young, 1990)[1] has been developed to help people with complex problems, and this involves much greater emphasis on the past. There are instances, however, when a person develops difficulties that are related not to unhelpful beliefs formed in early life but to those formed more recently. For example a person with panic disorder may have developed the belief 'if I panic I could die' after being told by someone that panicking is bad for the heart. Clients who wish to talk about early experiences may be helped to learn how to explore how these affect them now.

2 The therapy relationship is ignored in CBT

In reality, cognitive therapy stresses the

importance of the therapy relationship, and of communicating core skills of warmth, openness, empathy, and respect. Therapy is based on counsellor and client collaboratively testing the usefulness of the client's interpretations, and a positive alliance can be crucial to the facilitation of change. Recent years have seen increasing interest in the process of the therapy relationship, particularly when working with people with complex problems. In such work the beliefs being explored in counselling may be readily activated in the counselling room; for instance a client who believes that they are unlovable and that others are untrustworthy may perceive the therapist as uninterested in them. The therapeutic relationship becomes a central focus in such work, aiming to provide a vehicle through which the examination and testing of such beliefs can take place, together with the development and testing of alternative beliefs.

3 CBT is not interested in emotions, only in thinking

Clearly people generally do not present for counselling because of their thoughts, rather they are more likely to wish to do something about the distress they feel – and ultimately cognitive therapists aim to help with this emotional distress. Since emotions are so frequently related to thoughts and beliefs, however, intervention at the cognitive level is a convenient way to do so. Some people 'think' in images more than words and cognitive therapists may also intervene at this level. Of course CBT is also very interested in a person's behaviour, not just their thinking and emotions. In CBT, the distressing feelings that a person wants help with will be targeted and indeed may be intentionally activated in order to explore the meaning of the situations prompting them, and to provide information about the behaviours that follow them. Thus, the viability of these meanings can be tested.

4 Cognitive therapy is just about applying techniques

While many techniques are used in CBT, the approach emphasises the centrality of case conceptualisation, which offers a hypothesis about the maintenance of an individual's difficulties. This conceptualisation guides the particular techniques used with a client within the cognitive therapy structure. The aim is that the techniques that the client learns within this structure will remain useful to them after counselling has ended, to help them deal with future difficulties.

5 CBT is about stopping 'irrational' thoughts

Many cognitive therapists avoid the term 'irrational', which suggests a 'right' and a 'wrong' way to think about something. Therapists who adopt a very 'rationalist' view adhere to the notion of an 'objective' reality and may concentrate on helping the client to correct their 'cognitive errors'. Others, who instead take a more 'constructivist' view, consider that each of us constructs our own unique sense of reality (Winter and Watson, 1999)[2]. Here therapy may be used to explore the helpfulness to the client (rather than the validity) of their meaning system. Padesky (1993)[3] argues against the use of questions designed to 'change minds', to move the client from their ('logically flawed') viewpoint to the therapist's (so called 'rational') viewpoint in favour of those that help the client uncover relevant information they already have but which is currently outside their focus. We all typically attend to information that is congruent with our mood so, for example, a depressed person is more likely to attend to the fact that they did not answer all the questions in an exam than to think about contradictory information, for example that they answered some of the questions well. However a client may be able to do the latter with questioning that promotes this. Padesky advocates that therapists should not be 'headed' toward any particular answer in their questioning, but that instead they curiously and genuinely help the client to make their own discovery. To Padesky and many others, cognitive therapy is not about 'changing irrational thinking' but is 'a process of teaching clients to evaluate their thoughts, behaviours, moods, life circumstances, and physiological reactions to make choices that are adaptive'.

CBT in the university counselling service

There are several ways in which the CBT approach fits well within the higher education counselling service setting.

Short-term work

As in the NHS, there is increasingly an emphasis in HE on short-term work. Developmentally, young adults are characterised by the drive towards independence and autonomy and therefore for many, short-term work will be most desirable and appropriate. CBT of course lends itself well to this. Also, in an increasingly demanding environment it is particularly important to make best use of limited resources.

Guidelines predicting suitability of short-term CBT have been developed (Safran, Segal, Shaw and Vallis, 1990)[4]. These suggest that clients are more likely to find such work useful if they are able to access automatic thoughts, and have awareness of and are able to differentiate emotions. In addition they should be able to accept responsibility for change, find the cognitive rationale relevant to them, and be able to stay focused on the problems being targeted. Short-term CBT is less likely to be suited to clients with more chronic problems or to those who are not likely to readily form a working alliance, or who feel hopeless about the degree of change possible through therapy. Clients who frequently engage in avoidant behaviour in counselling (for instance those who struggle to openly explore anxiety-provoking subjects) may also be less likely to find short-term CBT helpful. In practice this can create a dilemma; is it better to offer a person with complex problems a short contract of CBT (with very limited goals), to refer them to the NHS taking into consideration its extensive waiting lists and strict criteria for referral, or to offer them longer-term work and risk our own waiting list overflowing? These questions affect all counselling teams and there are probably no easy answers.

Relevant to university setting

There has been a steady increase in the severity of mental health problems of students presenting for counselling

(Royal College of Psychiatrists, 2003)[5]. CBT has a solid evidence-base in the treatment of difficulties such as depression, anxiety disorders, bulimia nervosa, pain, fatigue and post-traumatic stress disorder (DOH, 2001)[6]. A model of, and intervention for, low self-esteem has also been developed (Fennell, 1999)[7]. As such, it offers potentially useful interventions for many of the common emotional difficulties that students experience. Alongside individual work, CBT has a long history of providing group work, and groups dealing with such topics as anxiety and stress management may be highly relevant to educational settings.

Research has an important role within universities, providing academic credibility as well as a real contribution to the advancement of knowledge. Increasingly, the counselling profession as a whole is becoming involved in research. As well as aiding clinical effectiveness, this may provide a powerful means to demonstrate the contribution of counselling to meeting the goals of the institution (for example its role in improving student retention rates). CBT emphasises the importance of research in testing the strength of theories and the effectiveness of therapies, and many CBT practitioners are interested in pursuing research activity.

Self-help

Self-help is popular with many people, offering information on how to respond usefully to particular difficulties, in privacy and at a convenient time. CBT lends itself well to self-help, with its structure and its emphasis on the active part the client plays in learning new skills and putting them into practice. A number of self-help cognitive therapy manuals are available. These may be used alone or in conjunction with counselling, and may lead to a sense of increased control over one's situation. Making known and valued texts available in university libraries may provide a helpful as well as cost-effective service. Given the wealth of existing self-help material, some useful and some not, counselling services may thus increase the likelihood of their students accessing those which may be of most benefit.

In recent years, computerised CBT (CCBT) self-help packages have also been developed, and have been introduced into some NHS services for use by patients with a number of common mental health difficulties including depression, panic disorder and bulimia nervosa. Preliminary evaluations of these are encouraging. CCBT may have advantages over bibliotherapy in that greater interactivity is facilitated and the format is more varied, potentially promoting lengthened concentration and interest. To my knowledge CCBT has not been used with students within HE although it is possible that it could be useful to this population. With this in mind our service is conducting research into the acceptability of CCBT to the student population and we hope to be able to publish our results in 2006.

New approaches

While traditionally CBT emphasises challenging unhelpful thinking, there is a growing interest in a therapeutic approach that focuses more on accepting thinking without altering it. Mindfulness-based cognitive therapy (MBCT) has been developed by Segal, Williams and Teasdale (2002)[8] to help break the cycle of recurrent depression. Mindfulness can be described as paying attention to one's moment-to-moment experience, on purpose and without judgment. Mindfulness practice can help us learn that thoughts are simply mental events and not necessarily reflections of reality, and that as such they do not need to be changed or stopped, nor do they need to be judged. By becoming more aware of our thoughts (as well as our emotions and physical states) we may disengage from them and respond skilfully, with choice, rather than engaging in the frequently unhelpful responses that can automatically follow them. The approach may be helpful for a wider group than those with chronic depression, and a colleague and I are in the process of facilitating a pilot group based on the MBCT approach for interested students to explore its credibility and impact for this group.

Conclusions

CBT is not the universal panacea that it can wrongly be seen as, but it is reasonable to suggest that providing CBT within university counselling services is desirable since it offers effective treatments for many problems that students ask counsellors for help with. Clinicians using this approach may also contribute to research and CBT-oriented self-help. If counsellors in teams in which different approaches are represented are willing to learn from each other non-defensively, it is possible that each other's misconceptions may be removed. This may pave the way for greater tolerance and understanding, and may serve to assist the development of highly effective services catering flexibly to the emotional needs of the student population. ■

Nicky Mitchell is a counsellor at Portsmouth University counselling service.

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