



*The Oxford Cognitive Therapy Centre (OCTC) was founded in the mid-1990s, when Dr Joan Kirk gathered together a small group of Oxford cognitive therapists to consider how we might best survive yet another round of NHS budget cuts. Twenty-five years later, three of that original group - **Helen Kennerley, Gillian Butler** and **Melanie Fennell** - met with OCTC's new lead, **Dr Sarah Rakovshik**, to reflect on the past quarter of a century.*

Twenty-five years of CBT: an OCTC perspective

There was a clear consensus that CBT is a psychotherapy success story, but in good cognitive therapist tradition, we were curious as to why.

One of our team (Melanie Fennell), suggested that three core characteristics/principles might have a substantial role to play in the longevity and popularity of CBT.

1. It is theory driven

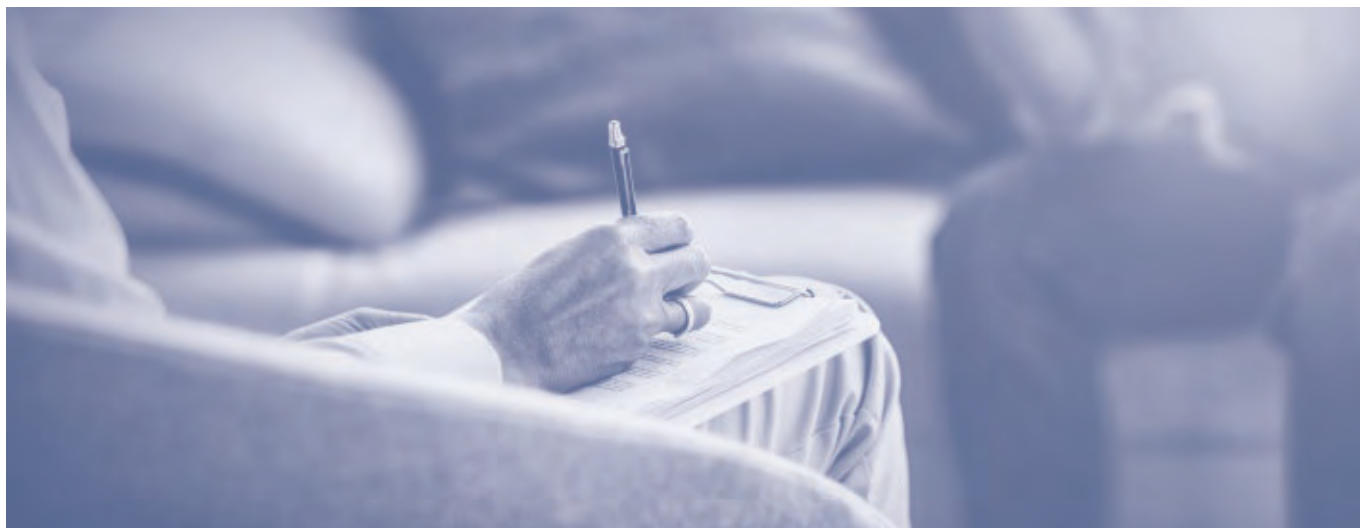
Not just in terms of highly specific models of particular disorders, but as a reflection of human functioning that can explain in a readily understandable way how people become, remain and recover from distress. Hands up anyone who can't see themselves in it? The original depression model provided a clear and flexible template to work with. This flexibility is clear when we consider the extraordinary range of different problem areas for which highly specific models and demonstrably effective treatment protocols have been successfully developed. The theory includes both learning and maintenance processes (e.g. avoidance of one kind or another, getting tangled up in one's own thinking), and it applies across diagnostic boundaries. Indeed, the processes identified are not exclusively related to serious psychopathology. Rather, the emphasis on normal human processes is clear throughout.

2. It is relationship based

CBT works through a warm, empathic, respectful, and – above all – collaborative therapeutic relationship. Collaboration is central. Through a process of inquiry and experimentation CBT encourages people to get curious about their own thinking, feelings and behaviour, and to be willing to explore new ways of operating through direct action (behavioural experiments). So it encourages direct experiential learning, the most effective means of encouraging deep processing, accurate recall, and the capacity to use knowledge and skills independently in the real world, both between sessions and after therapy has finished.

3. It is empirical

Not just in the sense of emphasising the importance of action/experience, but also science based. We have Aaron T Beck to thank for this. His habit of scientific thinking has remained integral to the approach. This has led to a substantial and growing evidence base, which, in turn, has encouraged bodies such as universities as well as the NHS to see CBT as something worth pursuing and developing. MBCT provides a particularly good example: it's hard to imagine something so apparently foreign to western psychology being recommended as a treatment of choice for depression without the scientific validation research gave it.



There is probably a good deal of support for the view that the interplay of these principles creates something that is more than the sum of its parts. This is because good CBT goes beyond sound technical skills and an ability to appreciate the therapeutic alliance. A good CBT practitioner delivers therapy with rigour **and** flexibility; draws on general **and** specific skills; reflects the application of art as well as science (an observation made by Gillian Butler).

We have all benefited from, and indeed been actively involved in, teaching and training over the past 25 years and our discussion reminded us just how vital it is that contemporary training continues to embrace these characteristics. It is crucial that CBT is taught as something more than a collection of technical skills, despite its emphasis on using specific, theory-based skills. CBT has been a success because it is a living, breathing therapy. That's why it has been so adaptable, growing and developing in numerous exciting directions.

In the early 1980s, three of us were working in the Oxford University Department of Psychiatry where we witnessed this blossoming of CBT first-hand. In the space of a few years from the publication of Beck's *Cognitive Therapy of Depression* in 1979, CBT's robust psychological framework was being applied to several anxiety disorders, eating disorders, somatic problems – and always with a healthy respect for the empiricism that has become its hallmark. Protocols began to be refined for a range of specific problems and practitioners from a variety of backgrounds could, relatively quickly, be trained to apply them. CBT was becoming more and more accessible from primary care through to highly specialist services.

Over the last 25 years, CBT has been applied to a seemingly ever-increasing set of psychological problems: medically unexplained symptoms, complex trauma, personality disorders, chronic depression, bipolar disorders – the list goes on.

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There was a myth that suggested CBT was a relatively superficial method, and not appropriate for people with longstanding and complex problems. This was refuted early on in its history. CBT is versatile, and its more sophisticated applications, which combine principle-based work with a highly individualised approach, now help many people who suffer from chronic and complex problems.

This is not a case of the same old format being rolled out with different disorders. Yes, key principles have been maintained, but the emphasis on particular elements of the CBT approach has evolved to reflect the distinctive qualities of particular disorders and the idiosyncratic needs of the patient or patient group. More recently, research has shown us what is key to the successful application of CBT in different specific problem areas. We have seen, for example, an emphasis on modelling and role play with social anxiety, the importance of understanding meta-cognition in GAD, and chronic depression; the value of imagery work in PTSD or in bipolar disorder.

The flexibility of the approach, the importance of not automatically rolling out the same old format, came to the forefront again when the need to increase the accessibility of CBT became a pressing issue. Twenty-five years ago, much CBT was offered in conventional mental health settings, but we now know that it can flourish in other health settings, in non-health settings, and via virtual and online delivery. Importantly, the ongoing evaluation of CBT's effectiveness in routine clinical practice continues to expand.

The most striking example of adapting CBT delivery to the times must be the IAPT initiative, the brainchild of Professor David Clark and Lord Richard Layard. Launched in 2008 with direct

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government funding, IAPT combatted the most common of psychological problems: anxiety and depression. Although IAPT does not exclusively offer CBT, it is the predominant therapy used, which meant that a contemporary means of training 1,000 additional CBT therapists per year had to be devised. Accountable to the government, the impact of the training and clinical interventions was carefully evaluated. Year by year more therapists have been trained, more IAPT services opened and because the outcome data has been compelling, the subsequent government-supported IAPT service has expanded to the treatment of children, those with co-morbid conditions and those with severe-mental illness and long-term physical conditions.

In the past quarter of a century, there has also been an enormous increase in developing the means of CBT dissemination: training, supervision and research. Even before OCTC had been established, Drs Melanie Fennell and Joan Kirk set up a CBT training course in Oxford. In response to the comments from graduates of the course, Melanie developed a Diploma/MSc in Advanced CBT studies, designed specifically to help experienced CBT therapists to move to the next level – honing the skills of dissemination. We have continually been guided by those principles of theory, relationship and empiricism. Our training was based on the best contemporary theory available to us, but we also turned to our student body to understand their needs and feelings, and we have never stopped evaluating. Along with other sites in the UK we offered the sort of training that would soon be recognised by the BABCP as essential when it laid out criteria for accreditation as a CBT Supervisor and Trainer.

The Oxford course in Advanced CBT studies no longer exists, but that's not a bad thing because it has evolved in response to the needs of students, and the financial and political climate. It is now delivered in a way that is more appropriate for clinicians working in a time of co-existing health service cuts and health service advances; that is, it is modular and allows specialisation for particular clinical populations. This responsiveness echoes what we have already noted about successful CBT clinical practice and service delivery.

If asked to predict what will happen to CBT over the next quarter century, we would have no hesitation in saying that it will be a survivor, as we continue as we started – with curiosity, humanity and empirical integrity. It has the adaptability, robust theoretical base and empirical foundations to survive. Not without changes, of course, but still recognisable, useful and effective. ■

Recommended reading

Beck, A.T., Rush, A.J., Shaw, B.F. & Emery, G. (1979). *Cognitive Therapy of Depression*. Guilford Press, New York.

Beck, A T, & Haigh, E A. (2014). *Advances in cognitive theory and therapy: The generic cognitive model. Annual review of clinical psychology, 10*, 1-24.

Salkovskis, P M. (Ed.). (1997). *Frontiers of Cognitive Therapy*. Guilford Press.

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