Theory, Research, and Practice of Cognitive Behaviour Therapy in Aotearoa/ New Zealand: Introduction to the Special Feature

Nikolaos Kazantzis
(Guest Editor)
Massey University

Cognitive therapy, or cognitive behaviour therapy, as espoused by Aaron T. Beck (CBT: A. T. Beck, Rush, Shaw, & Emery, 1979), was formulated drawing on the theoretical contributions of Adler, Allport, Piaget, and George Kelly. Originally developed as an explanatory model and therapy for depression (A. T. Beck, 1963, 1964), cognitive theory has lead to conceptual models for many disorders including anxiety (A. T. Beck, Emery, & Greenberg, 1985; Clark, 2004; Heimberg & Becker, 2002; Najavits, 2001; Taylor, 2004), addictions (A. T. Beck, Wright, Newman, & Liese, 1993), bipolar (Basco & Rush, 2005), eating (Fairburn & Brownell, 2002; Garner, Vitousek, & Pike, 1997), personality (A. T. Beck et al., 2003), and psychotic disorders (Kingdon & Turkington, 2005; Rector & A. T. Beck, 2002). These CBT applications began with cognitive conceptualizations drawing on the basic tenets of the cognitive model.

CBT is based on the premise that psychological disorders are determined by the meanings that individuals' make of events, rather than the events themselves. The constellation of core beliefs and assumptions that individuals develop in their early childhood are critical to understanding later perceptions of events, and their associated behavioral and interpersonal strategies. A core emphasis of CBT is to provide individuals with cognitive and behavioral skills to facilitate adaptive functioning and improved well-being. CBT is a short-term structured therapy that requires the therapist to conceptualize (or formulate) the client in cognitive terms, to facilitate understanding of emotional, behavioral, and physiological patterns (J. Beck, 1995, 2005; Dobson, 1999; Leahy, 2004; Persons, 1989). And, of course, the therapy depends upon a strong therapeutic relationship, a collaborative empiricism between therapist and client, in order to ensure that the client can progress towards their therapy goals and prevent distress in the future.

CBT is comparable in effectiveness to antidepressants and interpersonal or psychodynamic therapy for depression (DeRubeis et al., 2005; Hollon et al., 1992; Pampallona et al., 2004; Scott et al., 2003). In combination with antidepressants, CBT has been shown to effectively manage severe or chronic depression (Schatzberg et al., 2005). There is published data to support the utility of the approach for a variety of anxiety disorders, substance abuse, eating disorders, and, as an adjunct to medication, bipolar disorder and schizophrenia. Its efficacy has also been demonstrated in the treatment of hypertension, fibromyalgia, irritable bowel syndrome (Segal, Toner, Shelagh, & Myran, 1999), and chronic pain (Thorn, 2004). The empirical support for CBT is undoubtedly one of the reasons it is such a popular and flourishing approach in Aotearoa/ New Zealand.

Practicing psychologists utilize CBT as a key approach to their assessment and treatment services in the fill range of public and private sector health settings (Blampied, 1999; Kazantzis & Deane, 1998). CBT is strongly represented in the postgraduate clinical psychology training programme conducted by the psychology departments of the major universities (Evans, 2002). The popularity of empirically-supported approaches is likely to increase in the wake of the legislated mandate for the use of scientific evidence to inform and guide the practice of psychology.

The purpose of this Special Feature in the *New Zealand Journal of Psychology* is to provide a

forum for the dissemination of the empirical and clinical work being conducted on cognitive and cognitive-behavioural therapies. The goal was to provide a representation of the current work in CBT being carried out by psychologists in this country. The original call for papers was an open invitation for empirical, theoretical, review, and case discussions. The diversity in the papers presented in this feature issue indicates that the local work on CBT is thriving and rapidly evolving.

It is widely accepted that CBT is a popular influence to clinical psychology research and practice in New Zealand and elsewhere. The integrative theoretical foundations and strong empirical evidence are pinpointed as two candidates explaining the contemporary appeal of CBT in the invited paper by Paul Merrick and Frank Dattilio. The flexible application of CBT, as a process tailored for the individual's needs and goals, together with the emphasis on pragmatic skills also represent important considerations.

The scientific method is central to the practice of CBT. Therapy involves formulating hypotheses, collecting data, setting up experiments, and evaluating the data that results. An assumption of CBT is that when clients are actively engaged in this process of hypothesis testing, and extend their learning to the everyday situations and relationships in which they experience emotional distress, they are more likely to receive short and long term therapeutic benefits (Kazantzis, Deane, Ronan, & L'Abate, 2005). Laura Bogalo and Rona Moss-Morris present the results of an outcome study examining client engagement in between-session assignments, also called homework, in CBT for irritable bowel syndrome.

The development of a strong therapeutic bond and alliance is considered essential to effective CBT. The development of a 'collaboration', where the client and therapist join as a team to address therapy goals, depends upon the therapists' own interpersonal skills and understanding of their own pervasive beliefs, assumptions, and interpersonal strategies. Beverly Haarhoff presents preliminary data on therapists' cognitions and discusses the implications for clinical training and supervision.

With new conceptual models being developed for client groups and disorders, there is excellent opportunity to evaluate their utility for clients in New Zealand. A good example of the application of the use of multiple-baseline research methodology is provided by Jacqueline Feather and Kevin Ronan, who report a pilot study of trauma-focused CBT for children with posttraumatic stress disorder. The paper by Lois Surgenor, Jacqueline Horn, and their colleagues present the results of a study examining the role of control beliefs in alcohol dependence, and drawn inferences about the role of control beliefs as a potential mechanism of action in CBT.

The Special Feature ends with a detailed case study of the application of CBT for older Chinese woman by Mei Wah Williams, Koong Hean Foo, and Beverly Haarhoff. The article highlights some of the unique clinical considerations and notes that Western health models and services are under-utilized among Chinese in New Zealand.

Although limited in their representativeness of all theoretical, empirical, and clinical practice work being conducted, this collection of papers indicates that CBT is growing in its influence for the design, provision, and evaluation of psychological interventions in New Zealand. The 2002 Special Feature "Clinical Psychology in early 21st century Aotearoa/New Zealand" published in volume 31 of the *New Zealand Journal of Psychology* noted that local training and practice reflected CBT developments occurring the United States and Britain. On the one hand, it appears that there has been a clear continuation of the role of CBT in theoretical, empirical, and clinical practice being conducted in this country. Yet on the other hand, we are still on the first step towards to evaluating the appropriateness and suitability of CBT for our local context.

In accordance with the principles of the Treaty of Waitangi, there is a great need for psychology to consider whether CBT is culturally responsive to Maori aspirations and values. Understanding whether the assumptions and practices of CBT are respectful and responsive to the needs of our tangata whaiora is required. Article 3 of the Treaty requires that we ensure equity of the result or outcome of the services we provide for Maori and non-Maori individuals. It is hoped that Maori and Pacific perspectives can be represented as a focus for the evolution of CBT in Aoteroa/ New Zealand.

References

Basco, M.R., & Rush, A.J. (2005). *Cognitive-behavioral therapy for bipolar disorder* (2nd ed.). New York: Guilford.

Beck, A. T. (1963). Thinking and depression: Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry, 9*, 324-333.

Beck, A. T. (1964). Thinking and depression: Theory and therapy. *Archives of General Psychiatry, 10*, 561-571.

Beck, A.T., Emery, G., & Greenberg, R. (1985). *Anxiety disorders and phobias: A cognitive perspective.* New York: Basic.

Beck, A. T., Freeman, A., Davis, D. D., and Associates (2003). *Cognitive therapy of personality disorders* (2nd ed.). New York: Guilford Press.

Beck, A.T., Rush, A.J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford.

Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse.* New York: Guilford.

Beck, J.S. (1995). *Cognitive therapy: Basics and beyond.* New York: Guilford.

Beck, J. S. (2005). *Cognitive therapy for challenging problems: What to do when the basics don't work.* New York: Guilford Press.

Blampied, N. M. (1999). Cognitive-behaviour therapy in Aotearoa/New Zealand. *The Behavior Therapist, 22,* 173-178.

Clark, D. A. (2004). *Cognitive-behavioral therapy for Obsessive Compulsive Disorder.* New York: Guilford Press.

DeRubeis, R. J., Hollon, S. D., Amsterdam, J. D., Shelton, R. C., Young, P. R., & Salomon, R. M., et al. (2005). Cognitive therapy vs. medications in the treatment of moderate to severe depression. *Archives of General Psychiatry, 62,* 409–416.

Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmaling, K. B., Kohlenberg, R. J., Addis, M. E., Gallop, R., McGlinchey, J. B., Markley, D. K., Gollan, J. K., Atkins, D. C., Dunner, D. L., & Jacobson, N. S. (2006). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. *Journal of Consulting and Clinical Psychology, 74,* 658-670.

Dobson, K.S. (Ed.) (1999). *Handbook of cognitive-behavioral therapies* (2nd Edition). New York: Guilford Press.

Evans, I. M. (2002). Clinical psychology in early 21st century Aotearoa/New Zealand: Introduction to the special issue. *New Zealand Journal of Psychology, 31,* 50

Fairburn, C. & Brownell, K. (Eds.) (2002). *Eating disorders and obesity: A comprehensive handbook* (2nd ed.). New York: Guilford Press.

Garner, D., Vitousek, K.M. & Pike, K.M. (1997).Cognitive-behavioral therapy for anorexia nervosa. In Garner, D.M. & Garfinkel, P.E. (Eds.).*Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 94-144). New York: Guilford Press.

Heimberg, R.G., & Becker, R.E. (2002). *Cognitive-behavioral group therapy for social phobia.* New York: Guilford Press.

Hollon, S. D., DeRubeis, R. J., Evans, M. D., Wiemer, M. J., Garvey, M. J., Grove, W. M., & Tuason, V. B. (1992). Cognitive therapy and pharmacotherapy for depression: singly and in combination. *Archives of General Psychiatry, 49,* 774–781.

Kazantzis, N., & Deane, F. P. (1998). Theoretical orientations of New Zealand psychologists: An international comparison. *Journal of Psychotherapy Integration, 8,* 97-113.

Kazantzis, N., Deane, F. P., Ronan, K. R., & L'Abate, L. (Eds.). (2005). *Using homework assignments in cognitive behavioral therapy.* New York: Routledge.

Kingdon, D. & Turkington, D. (2005). *Cognitive therapy of schizophrenia.* New York: Guilford Press.

Leahy, R. L. (Ed.) (2004).*Contemporary cognitive therapy.* New York: Guilford Press.

Najavits, L. M. (2001). *Seeking safety: A treatment manual for PTSD and substance abuse.* New York: Guilford Press.

Pampallona, S., Bollini, P., Tibaldi, G., et al. (2004). Combined pharmacotherapy and psychological treatment for depression: A systematic review. *Archives of General Psychiatry, 61,* 714-719.

Persons, J. B. (1989). *Cognitive therapy in practice: A case formulation approach.* New York: Norton.

Rector, N. A., & Beck, A. T., (2002). Cognitive therapy for schizophrenia: From conceptualisation to intervention. *Canadian Journal of Psychiatry, 47,* 39-48.

Scott, J., Palmer, S., Paykel, E., et al. (2003). Use of cognitive therapy for relapse prevention in chronic depression. Cost-effectiveness study. *British Journal of Psychiatry, 182,* 221-227.

Schatzberg, A. F., Rush, A. J., Arnow, B. A., Banks, P. L. C., Blalock, J. A., Borian, F. E., Howland, R., & Klein, D. N. (2005). Medication (Nefazodone) or psychotherapy (CBASP) is effective when the other is not. *Archives of General Psychiatry, 62,* 513-520.

Segal, Z. V., Toner, B. B., Shelagh, D. E., & Myran, D. (1999). *Cognitive-behavioral treatment of irritable bowel syndrome: The brain-gut connection.* Guilford Press.

Taylor, S. (2004). *Advances in the treatment of posttraumatic stress disorder: Cognitive-behavioral perspectives.* Springer Publishing.

Thorn, B. E. (2004). *Cognitive therapy for chronic pain: A Step-by-Step Guide.* New York: Guilford.

Acknowledgements

The author expresses a warm note of thanks to the contributors to this Special Feature. The Feature would not exist without their contributions, and the work of senior psychology researchers and practitioners who contributed anonymous peer reviews. The support and guidance of the *Journal* Editor, Michael O'Driscoll has also been crucial to this issue.

Address for correspondence:
Nikolaos Kazantzis,
PGDipClinPsych, PhD
Centre for Psychology
School of Psychology
Massey University, Albany
Private Bag 102 904
North Shore Mail Centre
Auckland, New Zealand.

N.Kazantzis@massey.ac.nz