Chapter 3
Beyond cognitive behavioural therapy

LEARNING OBJECTIVES

After reading and studying this chapter and participating in lecture and discussion, students should be able to:

1. Describe the nature of the evolution of theories and therapies included in the so-called 'third wave' therapies.
2. Consider the role of common factors in a range of DSM disorders and the trans-theoretical approach that attempts to explain them.
3. Understand the development and nature of the Self-Regulatory Executive Function (S-REF) model and its associated therapy: metacognitive therapy.
4. Understand the concept of mindfulness as a 'stand-alone therapy' and as incorporated in a number of 3rd wave therapies including metacognitive and Acceptance and Commitment Therapy (ACT).
5. Outline the theoretical underpinnings of ACT (relational frames theory) and the basic principles and therapeutic strategies of ACT.

CHAPTER OUTLINE

1. Beyond CBT
    a. The third wave: an introduction

2. The trans-theoretical model

3. The Self-Regulatory Executive Function (S-REF) model
    a. Metacognitive therapy
    b. Mindfulness
    c. Attention control skills
    d. Metacognitive formulation and treatment approaches

4. Relational frames theory
    a. Acceptance and Commitment Therapy (ACT)
        i. The goals of ACT
        ii. The process of therapy

QUESTIONS FOR DISCUSSION

The types of therapeutic approach addressed in this chapter likely go beyond the previous experience and knowledge of students. If teaching involves a blended approach with students reading around the area prior to lectures, it may be these can be addressed early in the teaching session. However, the questions here may be better asked following the session.

1. Which of the following is NOT a focus of Well's Self-Regulatory Executive Function?

    a. a conditioned emotional response to stressful contexts
    b. planning avoidant action
    c. attentional bias to distressing memories
    d. cognitive distortions preventing emotional change

2. Which of the following provides the theoretical underpinnings of Acceptance and Commitment Therapy (ACT)?

    a. Metacognitive processing
    b. Relational frames theory
    c. Systemic theory
    d. Compassion-focused theory

3. Which of the following best describes ACT?

    a. Radical behavioural therapy
    b. Adjunctive cognitive behavioural therapy
    c. A combination of humanistic and cognitive behavioural therapy

LECTURE SUGGESTIONS

The key message of this chapter is that the second wave therapies focused almost exclusively on cognitive content and were condition specific. While some third wave theories do still remain relatively condition specific (see discussion of schema therapy and dialectical behaviour therapy for the treatment of borderline personality disorder in chapter 11), the emerging importance of the trans-diagnostic approach, and therapies such as ACT and metacognitive therapy, have addressed commonalities across conditions.

Both the trans-diagnostic approach and S-REF model progress cognitive models to involve process factors as well as content. In both, processes such as attentional bias towards threat and biased recall of memories are critical to both the aetiology of problems and their treatment, and allow for shifting approaches to therapy. A further addition is the idea of the individual having a plan of action for how to respond to threat, which is activated in the presence of that threat.

As a simple example, a second wave cognitive therapy approach to the treatment of a spider phobia may involve some form of cognitive challenge to any catastrophic thoughts about spiders that an individual may hold, within a programme exposure to spider-related stimuli. By contrast, the S-REF model assumes that such catastrophic thoughts are only some of the

beliefs an individual may hold in relation to spiders. Other beliefs may be benign and less catastrophic. However, the catastrophic beliefs become dominant and are attended to in the presence of a spider (when the S-REF mode is activated), while benign beliefs are disregarded. Accordingly, instead of identifying and changing catastrophic cognitions, metacognitive therapy may identify pre-existing benign beliefs and shift attention to them in situations where previously they were unattended. In addition, previous action plans (usually involving avoidance or escape) are replaced by plans to interact with the feared stimulus while engaging in coping strategies such as mindfulness or focusing on benign beliefs. This is a process known as exposure with response prevention (with response in this care referring to the activation of avoidance strategies).

Of interest is that, while the S-REF and ACT have very different philosophies, the use of exposure with response prevention is also central to both types of therapy – indeed, it is also a key element of second wave therapies. In these, the most obvious examples are the use of exposure and response prevention for the treatment of anxiety and obsessional disorders. However, the treatment of affective disorders also incorporates this approach through the process of behavioural hypothesis testing. Accordingly, while the theories underpinning third wave approaches have either nuanced psychological theories (the S-REF) or rejected them and adopted radical behavioural approaches (relational frames theory), the final therapeutic 'product' has many similarities with the second wave.

Perhaps the biggest difference that the third wave therapies bring to treatment is the use of mindfulness as a means of coping with exposure to threatening stimuli and contexts. Rather than bringing catastrophic cognitions to mind and attempting to challenge and defuse them, mindfulness is used to defuse their dominance and make them simply another part of experience that do not have to be responded to either emotionally or behaviourally.

CLASSROOM ACTIVITIES

Potential discussion topics:

- **Small group discussion** Similar issue to that considered in the previous lecture. Do the theoretical explanations for emotional disorders and their treatment derivatives getting increasingly complex really help therapists be more effective? And when pared to the bone, do they differ that much from second wave therapies?

- **Case discussion in pairs** Consider the case of a woman with a fear of driving in her car, following the experience of a panic attack for no apparent reason while driving. Consider the second and third wave explanations where their interventions are the same, as well as where they differ. As can be seen below, the basic approaches probably have more similarities than dissimilarities. Italics are used to identify key differences.

Second wave

Cognitions

I'm feeling panicky... I'm going to lose control of the car!
I'm going to collapse... this is frightening!

Oh my heart is racing... a sign of real problems.
OK. Get out now!!!

Behaviour

Stop car by side of road.
Avoid driving or driving where panic was experienced.

Intervention

Graded exposure to situations in which panic is likely to be experienced
Cognitive challenge... learn to identify catastrophising cognitions and give self-reassurance.
Use of relaxation to reduce physiological reactivity and provide positive coping strategy.

Third wave

Cognitions

OK. I've got to try to avoid places where I had a panic before.
If I start to panic, I've got to drive away or stop driving.
Oh, I remember when I drove down there before, and I felt really bad…
I'm feeling panicky... I'm going to lose control of the car!
I'm going to collapse... this is frightening!
Oh, my heart is racing... a sign of real problems.
OK. Get out now!!!

Behaviour

Stop car by side of road.
Avoid driving or driving where panic was experienced.

Intervention

Graded exposure to situations in which panic is likely to be experienced
Use mindfulness or similar techniques to distance from emotional centrality of cognitions.
Use of relaxation to reduce physiological reactivity and provide positive coping strategy.
Be aware of plans of avoidance and do not engage with them.