REVIEW ARTICLES

Who is suitable for cognitive behavioural therapy?

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'People are not disturbed by events, but by the view they take of them'. This comment by the Greek philosopher Epictetus two thousand years ago aptly reflects the basic tenet of modern cognitive behaviour therapy (CBT)—that what people believe affects their emotions. CBT is structured, problem-oriented, and set in the here and now, and has rapidly become the treatment of choice for a wide range of mental health disorders. Its reputation as a pragmatic therapy rests on solid research evidence[1]. This article outlines the criteria for deciding suitability for short-term cognitive behaviour therapy (between 6 and 20 sessions) in terms of client profile, the disorder itself, and treatment setting.

SUITABILITY FOR PSYCHOTHERAPY IN GENERAL

Although many different talking treatments have been described, they have certain therapeutic principles in common. Such key features include a confiding relationship, instillation of hope, explanation of the treatment rationale, exchange of information, ventilation of emotion and acquisition of insight alongside the relearning of new behaviour[2]. Table 1 outlines currently accepted criteria for client suitability in general, originally derived from psychodynamic psychotherapeutic practice[3], which I have adapted and applied to the CBT perspective. There is a real danger that enthusiasts of a cognitive–behavioural approach can become technique driven and forget that success will depend on having a good therapeutic relationship at the core[4].

SUITABILITY ACCORDING TO PSYCHIATRIC DIAGNOSIS: AN APPROPRIATE PARADIGM?

Enright has undertaken an extensive systematic review[5] of the research available on all electronic databases in support of the major clinical applications of CBT. He focused on psychology, psychiatry and medicine using traditional diagnostic labels. After allowing for additional recent published research[6–10], I have graded his conclusions in Table 2 according to overall strength of evidence for efficacy.

Two points are relevant here. First, evidence in support of CBT does not imply absence of evidence for other talking treatments that have yet to be researched as extensively, or even that CBT is superior to them. A meta-analysis by Holmes[11] has shown that the different types of psychotherapy all have a similar effect size of around 0.8–1.0 (i.e. the average patient does better than 85% of controls).

Secondly, it is easy to see the appeal of the CBT approach, for there appears to be no physical or psychological problem that may not be assessed in this way. Even where its use has been described as contra-indicated, research exists to confirm its efficacy. Such examples include severe depression, where several out-patient studies have shown CBT to be no less effective than in the milder forms[12], alcohol excess, where CBT strategies may be useful in treatment[13], and even senile dementia in the earlier stages of cognitive impairment[14]. Indeed the potential of CBT, which emphasizes techniques such as problem-solving, goal-setting and decision analysis, can and

Table 1 **Client suitability for talking treatments in general**

Suitability for psychotherapy in general	*Particular relevance to a cognitive–behavioural approach*
Acceptance of psychological reasons for difficulties—that is, in some way to do with client	Ability to identify and define key problems is an important prognostic indicator
Motivation for change exists—willing to attend regular therapy sessions	Focused, active approach by client emphasizing importance of 'homework'
Able to access/identify own feelings Able to make psychological connections	Premise of improvement in emotions by identifying and modifying associated thoughts and behaviour
Able to form human relationships (at least one meaningful relationship in past)	Principles of Socratic questioning and collaborative approach rely on good therapeutic relationship
Those with non-chaotic life and without multiple long-term problems do best	Clear treatment goals, centred on one main problem, in those with intact personality
Good response to a trial interpretation or intervention	Positive response to presentation of cognitive behaviour therapy rationale with examples at assessment interview indicates more favourable prognosis
Adequate 'ego strength' (ability to tolerate anxiety, control impulses and test reality)	Includes exposure treatment to habituate anxiety, and behavioural experiments to test out beliefs

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Table 2 **Suitability for cognitive behavioural therapy according to psychiatric or medical diagnosis based on research evidence (adapted from Enright 1997, see Ref. 5)**

Current clinical status	***Examples***
Treatment of choice	Panic disorder; agoraphobia; simple phobias; generalized anxiety disorder*
Major role in clinical practice	Depression* (mild to moderate severity, not chronic); obsessive–compulsive disorder*; social phobia*
Moderate evidence base for efficacy	Bulimia nervosa*; post-traumatic stress disorder; sex therapy; pain in physical illness*; hypochondriasis; chronic fatigue syndrome; schizophrenia and other psychoses*
Minimal evidence of benefit at present	Personality disorder; low self-esteem; chronic depression/dysthymia; anger; insomnia*; anorexia nervosa; problem drinking*; drug dependence*; physical illness (arthritis, diabetes, asthma, eczema, hypertension, obesity)
?Contraindicated	Severe depression* (psychomotor retardation); organic illness* (e.g. delirium, dementia); heavy substance use* (alcohol, benzodiazepines)

*Psychotropic drugs an option

does have wider applications within the commercial and business world, and perhaps may also be usefully employed by career counsellors in various settings.

Hence we have a treatment for which there are, from a diagnostic perspective, apparently limitless indications and almost no absolute contraindications. Perhaps then the cognitive–behavioural approach represents not so much a specific treatment modality as a common-sense philosophy based on the principles of self-learning advocated by Socrates. In this respect, assessment of suitability according to a strict diagnostic system that does not take account of individual client differences will have limited usefulness.

SUITABILITY ACCORDING TO CLIENT CHARACTERISTICS: WHO WILL BENEFIT MOST?

Traditionally, clients considered suitable for psychotherapy in general have at least partially conformed to the YAVIS stereotype (Young, Attractive, Verbal, Intelligent and Successful). How does this view fit with the growing body of research evidence supporting the application of CBT according to age, intelligence and other client characteristics?

The principles of a behavioural approach have long been recognized as worthwhile in the treatment of *childhood* disorders, and more recently cognitive techniques have been successfully applied to disturbed older children and adolescents[5]. Conversely, *old age* in itself seems to be no barrier to effective CBT for conditions such as depression, at least for clients into their early seventies[15]. However, the elderly as a group may be less used to the idea of actively participating in their treatment[14], and therapists may need to be flexible regarding practical disabilities such as poor hearing, difficulty with writing and physical illness.

High *intelligence* likewise seems not to be a useful indicator of the probable success of CBT: over-intellectualization of practical problems by those with a high IQ can present a potential barrier to therapy[16], whilst behaviour therapy based on positive reinforcement of desired responses has been used even in those with severe learning disabilities[17].

Although the influence of *gender* upon outcome of short-term CBT is seldom mentioned by standard sources[1,18], women and men have to date been assumed to benefit equally. From the therapist viewpoint, a survey of British general practitioners using CBT techniques in their routine management of depression[19] revealed a tendency for male doctors to emphasize the challenging of automatic negative thoughts; female general practitioners more often used a diary-keeping approach and placed greater emphasis on collaboration with the patient.

What of the influence of *personality* upon suitability for CBT? This remains an under-researched area, although a treatment approach involving a high level of personal responsibility[18] is unlikely to be adopted by clients who have learned a passive coping style in their lives—i.e. those exhibiting a low internal locus of control. Fennell and Teasdale[20] believe that such low-self-control patients in general do better with medication, and high-self-control individuals with psychotherapy.

Some have suggested that the cognitive–behavioural approach is most likely to appeal to those individuals who are seeking relief of symptoms rather than a deeper insight driven desire for self-exploration[21] and who can adopt a pragmatic approach to problems. However, it would be a mistake to conclude that, because the cognitive–behavioural approach relies on simple techniques, it is of itself superficial and simplistic. A useful analogy here would be the difference between an operation to remove varicose veins and coronary bypass surgery. Both essentially involve just two procedures (cutting and stitching)—yet they undoubtedly require different levels of skill and understanding.

It is possible that a client's current or previous *occupation* may help to indicate his or her suitability. I have recently been successful with short-term CBT in a mechanical engineer who found that focal, task-oriented pragmatic skills used daily in his job could be quickly applied within therapy. In contrast, another client with an English degree and employed by the media had difficulty focusing upon specific issues and setting concrete targets for improvement. The hypothesis, as yet untested, is that individuals from a practical or scientific background are suited to problem-oriented therapy, whilst individuals from an arts background do better with a humanist or psychodynamic approach.

It remains to be seen whether the CBT style, developed in the western world and the United States in particular, will translate well to other *cultures*, especially in less developed countries. For example, the variant of CBT devised in the USA by Harold Ellis and known as rational emotive therapy (RET) directly challenges core beliefs and assumptions from the outset of therapy[22]. This approach ('psychotherapy for the insensitive, by the insensitive') represents a far more confrontational style than that of Beck, but what works for a New York taxi driver may not translate well even across the Atlantic.

A SUITABLE SETTING FOR CBT

Any discussion of suitability should consider the treatment setting. The Royal Colleges of Physicians and Psychiatrists have recommended that psychological care in general hospitals should be provided by the physician and associated staff, with the back-up of liaison psychiatric services for selected cases[23]. Existing evidence which supports the therapeutic effectiveness of cognitive–behavioural approaches in dealing with medical patients is summarized in Table 3. It has been agreed that specialist nurses can advise on practical coping skills (for example, in cardiac rehabilitation, diabetes, asthma and stoma care) whereas attached psychologists may usefully provide specific graded exposure treatment for phobias (such as fear of needles, dialysis, or chemotherapy). Whether medical psychotherapy should compete, collaborate or simply coexist with psychology services is currently being debated, alongside the work of a national steering group developing guidelines as to which patients are best suited to which psychotherapies[24].

If the true potential of CBT is to be recognized, then its application to the population at large outside of specialist departments of psychotherapy, psychology, and psychiatry will also need to be carefully evaluated. The national 'Defeat Depression' campaign (1992–1996) did encourage general practitioners to employ cognitive–behavioural techniques in their routine management of depression[25], and problem-solving therapy can be as effective as amitriptyline in the primary care setting[26]. However, the challenge must not only be to adapt CBT to the seven-minute consultation but also to educate general practitioners and their staff at a local level as to what to do (techniques and skills), and on whom to do it (selection

Table 3 **Application of cognitive behaviour therapy to psychological problems within the general medical setting**[23]

Disorder	Cognitive behavioural approach	Evidence with examples
Physical disease leading to psychiatric disorder		
Adjustment disorder	Help patient make more adaptive cognitive response to illness. Education. Goal setting. Coping strategies (e.g. distraction). Practical problem-solving	Decrease in chronic pain severity and dependence on family; improved activities of daily living in stroke[40]; reduced distress after myocardial infarction[41]
Generalized anxiety/panic disorder	Deal with uncertainty. Modification of catastrophic misinterpretation of physical symptoms, behavioural experiments, relaxation	Reduced anxiety and depression in cancer patients[39]. Stress management beneficial in epilepsy[42] and irritable bowel syndrome[43]
Depression	Activity scheduling. Challenge negative automatic thoughts, especially hopelessness	Established treatment choice in physical illnesses with or without antidepressant drugs[23]
Medical symptoms unexplained by physical disease		
Somatic presentation of primary anxiety and depressive disorders	Key is early detection. 40–70% patients with atypical chest pain have anxiety[44], up to 45% with fatigue or abdominal pain have depression[45]	Treatment as above
Hypochondriacal disorder	Increased focus upon and misinterpretation of, normal body sensations, reassurance seeking, avoidance	Controlled trials show improvement compared to waiting list controls in function and disease conviction[8,46]
Somatization disorder	Multidisciplinary coordinated approach essential. Explain symptom generation. Broaden agenda, 'coping not curing', make link with psychological problems and life events	Individual CBT shows specific efficacy in pain, dyspepsia and irritable bowel syndrome[47]. Group CBT reduces health care costs and improves mental health[48]
Chronic fatigue syndrome	Reduce 'boom and bust' activity fluctuations; set consistent goals; grade exercise. Challenge purely physical illness attribution using 'biopsychosocial' approach[49]	Randomized trials show effectiveness compared with relaxation therapy[9] and standard medical care[50]

criteria). The family doctor may here have an advantage over colleagues in secondary care, in that his or her knowledge of the patient's background may facilitate decisions regarding suitability and motivation.

SELF-HELP MATERIALS

Self-help books such as *Mind over Mood* by Greenberger and Padesky[27] offer one practical way to reach a wider audience. A randomized controlled trial by Fairburn and colleagues[28] has already shown that people with bulimia nervosa can benefit from CBT given as a self-help manual. However, this approach presumes that clients are able to determine their own suitability, and a very high degree of commitment is required for use in isolation. Perhaps self-help sources are more useful as a preparation for those already accepted as suitable by CBT therapists but on the waiting list, or by creative general practitioners, psychologists and counsellors who wish to maximize progress within time constraints. They cannot be firmly recommended until we have more evidence of benefit without therapist support and guidance.

SUITABILITY WITHIN THE NATIONAL HEALTH SERVICE: DEPRESSION AS AN EXAMPLE OF THE CONFUSION

Cognitive therapy was originally developed for the treatment of depression by A Beck in the USA over 25 years ago[18]. Since depression is one of the most extensively researched disorders in connection with CBT, one might expect CBT for this disorder to occupy a clearly defined position within a modern health service. Existing research indicates that CBT will work best for non-chronic unipolar, non-psychotic depression of mild to moderate severity, in those without gross personality disturbance[29]. However, the advent of modern antidepressant drugs such as fluoxetine has all but wiped out referral of such cases to psychotherapy departments in secondary care (N Macaskill, personal communication). Instead, CBT-trained therapists are facing the prospect of referrals, both from general practitioners and from colleagues in the mental health sphere, of those with more chronic depression, often unresponsive to medication, and with varying degrees of personality disturbance, for a 'trial of CBT'. Since there is currently little evidence to support the efficacy of CBT in chronic drug-resistant depression[30], its exact role must be open to question. When effective, antidepressant drugs are cheaper, are readily available to general practitioners, and have proven long-term benefits in the prevention of relapse of recurrent depression for at least three years[25]. The large NIMH study[31] which compared placebo, imipramine, interpersonal therapy and CBT treatments for depression indicated that all four treatment arms were effective for mild cases whereas medication was most beneficial in severe depression. Challenging the drug treatment approach, proponents of CBT could point to the need for choice amongst those who may be unable or unwilling to tolerate medication, together with the value of a therapy that teaches problem-solving skills for future use[32]. One large trial showed that cognitive therapy was superior to drug treatment when provided by a psychologist in the primary care setting[33]. Although CBT was here found to be more expensive, further research has indicated that in the longer term the use of pharmacological and psychological therapies in combination has economic as well as clinical advantages[34]. For example, Miller and colleagues[35] found that when CBT was added to routine inpatient treatment, 54% of patients remained well at one-year follow up, compared with only 18% offered usual care. In the future, CBT may pragmatically find a place in treatment of moderately depressed individuals who have coexisting interpersonal or other identifiable problems that are impairing the response to antidepressant medication.

WHY IS SUITABILITY FOR CBT IMPORTANT?

Clients with unfocused, multiple, or very chronic problems, including those with a diagnostic label of severe personality disorder, are unlikely to benefit from short-term CBT[5]. Although cognitive–behavioural therapists may be accused of offering their expertise to the least impaired, arguments for adopting a selective approach can be clearly justified on several grounds.

Efficient use of resources

The annual costs of neurotic disorder in the United Kingdom have been estimated at £600 million in direct medical costs and £5.6 billion (over one-third of the total cost of the NHS) in lost production (1994 figures[11]). If CBT can diminish this burden, it will prove its economic worth—but only if the most appropriate form of psychotherapy is offered to the most appropriate clients[36].

Determination of suitability is itself therapeutic

A focus on client motivation, and an attempt to arrive at a collaborative definition of the central problem and goals for therapy, can help to facilitate greater understanding about the nature of current difficulties. Such information processing at the assessment interview can be helpful to both client and therapist, whether or not CBT is subsequently offered. For example, those with relationship difficulties may instead benefit from interpersonal therapy or referral to voluntary services such as Relate.

Demoralization of both client and therapist

The disappointment of a client who does not respond may lead to a worsening of mental state[15], and could importantly reduce his or her confidence in, and compliance with, other treatments subsequently offered. Because of the current shortage of qualified CBT practitioners it is particularly important that therapists do not 'burn out' and stop seeing clients because of poor outcomes in individuals who were unsuitable for treatment.

The importance of image

CBT must not be seen as a panacea for psychological distress in all its forms. Attempts to treat unsuitable clients could easily lead to disillusionment amongst those in a position to support and fund a comprehensive CBT service in the future—hospital trust managements and general practitioners commissioning psychotherapy services through primary care groups.

WHAT ARE THE PRACTICAL IMPLICATIONS OF A SUITABILITY ASSESSMENT?

Referral from primary care

General practitioners should be aware of the following factors when deciding on patients' suitability for CBT.

(1) Clients should be requesting a practical method of treatment, to address a specific problem and to achieve specific goals or targets. Supportive counselling for those who wish simply to talk about their problems, or dynamic psychotherapy for those who want to 'understand myself better', should be considered as alternative talking-treatment options

(2) Clients should be made aware, preferably with the aid of a leaflet introducing CBT, of the active nature of therapy. They can be specifically informed that completion of assessment forms, diaries, and other regular homework tasks will involve a lot of hard work and require strong motivation

(3) Clients must be willing to accept and work with a psychological model that emphasizes the importance of modifying thoughts and behaviours

(4) General practitioners should give priority, in their referrals, to conditions such as phobias or panic disorder for which CBT is the accepted treatment of choice. Where there is an alternative more cost-effective option—for example, drug treatment in psychosis, depression or obsessive–compulsive disorder—this should be carefully considered.

Professionals working within general medical hospitals

(1) Individual clinical characteristics will influence the preferred intervention. For example, lying in bed all day because of chronic fatigue indicates a behavioural treatment (graded activity), whereas a cognitive approach will be more suitable for hypochondriacal patients with dysfunctional beliefs such as 'Investigations should be able to find a cause for my symptoms'[37]

(2) Those who are able to link their appraisal of physical symptoms (having been fully acknowledged as genuine by the physician) with their psychological reactions to the illness (emotional adjustment, thoughts and behaviour) may be most likely to benefit from CBT. In the chronic fatigue syndrome a strong belief that a purely physical disease process explains all symptoms predicts a poor long-term outcome[38]

(3) Programmes based on cognitive–behavioural principles have become the standard in the rehabilitation of those with chronic pain[23]. Patients who report more negative cognitions such as catastrophizing and hopelessness may especially benefit from modification of attitudes and behaviour in relation to their pain by the use of education, goal-setting, and group cognitive therapy[7]

(3) Suitability for CBT may be practically determined by assessing the patient's reaction to trial interventions. For example, in somatization disorder, getting the patient to hyperventilate to reproduce somatic anxiety symptoms, or demonstrating that a book on an outstretched hand causes pain but does not indicate organic muscle disease, are behavioural experiments that may be used to test out dysfunctional beliefs[23]. The response to cognitive interventions can also be evaluated, such as the following challenge to hopelessness and uncertainty in those with terminal or life-threatening illness: 'If you were to live twenty years, what would be your goals? Well, since you don't know how long you will actually live with this illness, is it not even more important that you try to achieve them now, starting in the next week?'[39].

Cognitive behavioural therapists

(1) Therapists should concentrate on assessing suitability for short-term (6–20 sessions) CBT for which efficacy has been clearly demonstrated[33]. Until the value of long-term CBT (12 months or more) for those with complex or personality-related problems is shown, this option should not be a funding priority[1]

(2) Although objective rating scales (such as the Suitability for Short-term Cognitive Therapy scale[16]) may be

helpful, the final judgment should be based on key practical aspects of clinical assessment at the screening interview (Table 4). Those who are likely to do best with short-term CBT usually accept that change is at least theoretically possible, can acknowledge the existence of alternatives to their negative views, and are willing to experiment with new ways of thinking and behaving both within therapy sessions and in homework self-help assignments[10]

(3) As CBT is a problem-based therapy, emphasis should be placed on this at initial assessment. Ideally, the client and therapist should be able to agree on a short, clear, written definition of the main problem. Levers for change will be greatest where the problem is active, reasonably predictable, and recognized by the client as an important handicap in life[32]. Specific and clear treatment goals can then be agreed collaboratively, with acknowledgment that any change may carry costs as well as benefits

(4) The offer of alternatives, such as referral to another mental health professional or the telephone number of a suitable voluntary organization, can lessen the anger or sense of rejection experienced by some clients who are judged unsuitable.

CONCLUSIONS

Suitability for short-term cognitive behaviour therapy can be assessed by an approach that is both systematic and evidence-based. Box 1 summarizes the key stages in the determination of whether or not short-term CBT will be an appropriate intervention. We need to achieve a balance between suitability criteria that are too stringent (resulting in the failure to offer treatment to those who may benefit), and those that are too relaxed (so that, for every client seen, others more likely to benefit are turned away). Individual client characteristics are probably as important in making this judgment as the diagnostic labels that have been attached. An effective suitability assessment should combine the science of research evidence with the art of clinical acumen.

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Table 4 **Practical indicators of suitability for cognitive behaviour therapy (CBT) at first assessment interview (based on Segal *et al.* 1996, see Ref 16)**

Indicator	*Assessment*	*Comments*
Acceptance of the CBT model	'How do you understand your difficulties?' Explanation, with examples, of how negative thoughts can adversely affect mood	Those insisting that cause is solely due to 'chemical imbalance' or a 'difficult upbringing' unlikely to fit model
Ability to access automatic thoughts	Identify recent upsetting situation for client: 'Are you aware of any thoughts or pictures running through your mind?' Note self-critical thoughts—for example, 'I'm a loser'	Draw attention to casual self-critical remarks made in interview as automatic thoughts e.g. 'I'm stupid'. Feed back and note response
Self-awareness of emotions	Ability to comment on shifts in mood and link to thoughts during therapy session	Indicates good prognosis if present
Ability to form collaborative relationship with therapist	Explore meaningful relationships in client's life and previous therapy In session note eye contact, posture, general openness and 'feel': 'tell me how you feel about what's going on between me and you right now'	Poor rapport during interview, and tendency to idealize or blame previous therapists not a good prognostic indicator
Capable of specific, focal therapy	Ability to describe recent typical example of own difficulties Ability to agree on short definition of the main problem and specific goals: 'I have noticed we are having trouble staying on one subject'	Beware a vague rambling approach, frequent topic changes, tangential discussions, intellectualization, or a desire to work on all problems at once
Personal responsibility for change	'How do you see your/my role in therapy?' Response to need for active involvement and homework	View as passive recipient of cure by therapist negates active CBT approach. Seeing change as possible in theory is positive
Duration of the problem	Explore onset, duration and course of current difficulties.	Acute, rather than long-term problems do best

Box 1 **Key stages in the determination of suitability for short term cognitive behaviour therapy (CBT)**

1 Are the necessary resources readily available within the local mental healthcare system (number, expertise, training and supervision of CBT and other psychotherapists, agreed referral criteria, waiting-list time reasonable)?

2 Is psychotherapy (as opposed to drug treatment, social intervention, or no intervention) the most appropriate option for this client at this particular time?

3 If so, does the client fit accepted criteria for suitability regarding talking treatments in general (Table 1)?

4 If so, does client have *either* a clearly defined current problem that is disabling, *or* a diagnosis for which research evidence indicates CBT is likely to work (Tables 2 & 3)?

5 If so, is CBT (as opposed to brief dynamic therapy, interpersonal therapy, or generic client-centred counselling) the most appropriate type of psychotherapy on evidence of the clinical assessment interview (Table 4)?

6 If so, in what setting will CBT occur?

(a) Self-help, voluntary sector or NHS

(b) Primary or secondary care

(c) Specialist dept of psychotherapy or within general psychiatry/psychology/medical services

(d) Group or individual therapy

7 Who will be the CBT therapist?

(a) Skill specific (e.g. consultant cognitive psychotherapist, psychologist or behavioural nurse therapist)

(b) Skill mixed (e.g. general practitioner, practice counsellor, member of the community mental health or medical team)

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