THIRD WAVE CBT THERAPIES

Brief Literature Review

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SDS Seminars Ltd, 2015

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Chapter 1
Introduction to Third Wave CBT

Background
The range of Cognitive Behavioural Therapies that have been developed and researched, can be seen to represent the influence of current theoretical thinking at the time and context within which they each developed. Each therapy therefore represents a progression of knowledge throughout previous decades. As such, psychological therapies are often grouped into various categories or ‘waves’, to reflect the similarities (and differences) they have with other psychological therapies. A wave can be understood as a set of dominant assumptions, methods and goals that can assist in the organisation of the theory and practice of these therapies (Hayes, 2004).

1st Wave CBT
The ‘first wave’ CBT therapies can be understood as being formed largely of behavioural methods, which grounded in scientific principles that could be measured through analysis and observation. Behaviourists understood human behaviour as resulting from various instances of conditioning, typically through the process of reinforcement, that guided human behaviour, as well as other animals. These processes provided a model to understanding anxiety, and the manner in which phobias could be understood to have originated.

These explanations also came to be incorporated into current cognitive-behavioural understandings of anxiety and phobias. The first-wave therapies, while centring on the processes of operant and classical conditioning, did not consider the roles of thoughts and feelings in human behaviour. This led to the development of the so-called ‘second wave CBT therapies’.
2nd Wave CBT

This development arose out of work on cognitive models of human behaviour in the late 1960s. These second wave CBT therapies, and the models that they produced gave attention to cognitive processes, specifically unhelpful or irrational thoughts, schemas, or what might deemed as a faulty information processing style. Central to second wave CBT therapies is the notion of interpretation as being influential in understanding human behaviour, and the thought processes that lead to the individual’s conclusions about an event (Hayes, 2006). Subsequently cognitive models were designed to illustrate how people can come to experience depression and anxiety.

Second wave CBT however did not ignore behavioural understandings of human behaviour, however. As a result, their incorporation led to the term cognitive - behavioural therapy (CBT). These models have become the dominant therapeutic model in the recommended treatment of various mental health problems in the UK by the National Institute of Clinical Excellence (NICE). These include depression (NICE, 2009), obsessive compulsive disorder (NICE, 2005) panic disorder and generalised anxiety disorder (NICE, 2011), to name just a few.

The overall focus of these first two generations of CBT therapy (the first of which simply Behaviour Therapy (BT)) was that they shared the assumption that particular cognitions and emotions lead to dysfunctional behaviour, and that the aims of therapy are to then eliminate, or reduce, these problematic, so called, “internal events”.

What defines 3rd Wave CBT?

Chronology?

The new “Third Wave” CBT Therapies represent a heterogeneous development within CBT which nonetheless shares common features. Strictly speaking there is no clear consensus on what defines Third Wave CBT. At a simple level, it can be new evidence based therapies that have
developed since 2\textsuperscript{nd} wave. However, even this is not agreed on within the literature. Kahl, Winter\& Schweiger (2012) for instance incorporate behavioural activation within third wave – a therapy developed in the early 1970s and subsumed by Beck within 2\textsuperscript{nd} Wave’s Cognitive Behaviour Therapy.

Typically however, the chronological development after 2\textsuperscript{nd} wave CBT is understandably accepted by most writers. Equally there is some degree of consensus regarding some of the therapies that can be labelled 3\textsuperscript{rd} Wave. Mindfulness, Acceptance & Commitment Therapy (ACT) & Dialectical Behaviour Therapy (DBT) are generally agreed upon as fulfilling the definition of 3\textsuperscript{rd} Wave Therapies.

**Thriving & Flourishing?**

Hayes (2004) has suggested that Third Wave CBT Therapies focus more on the importance of client thriving and flourishing rather than simply looking at a reduction in symptoms. This is certainly the case with a number of third wave approaches such as Mindfulness, Acceptance & Commitment Therapy (ACT) and Compassion Focused Therapy (CFT). It arguably feels more “stretched” as an argument when applied to Dialectical Behaviour Therapy (DBT) with its focus on Borderline Personality Disorder and “Difficult to Treat” problems. It may be more accurate instead, to state that 3\textsuperscript{rd} wave therapies have a focus that is not purely symptom based but rather addresses client values including values associated with relationships and identity. This would appear to apply to ACT, DBT and CFT.

**3\textsuperscript{rd} Wave as Contextual Therapy?**

Hayes (2004) again suggests another defining characteristic of third wave CBT is that it is “particularly sensitive to the context and functions of psychological phenomena, not just their form”. This conceptualisation has led many to state that 3\textsuperscript{rd} wave is about “Putting the “B” back into CBT”. 2\textsuperscript{nd} wave CBT was felt by many behaviourists (especially operant based radical
behaviourists) to have allowed cognitive therapy to subsume behaviour therapy rather than simply be joined with it. 3rd Wave CBT seemed to resuscitate radical behaviourist principles within CBT. However, this again appears to be true of some therapies under the 3rd wave heading but not others. ACT most clearly fulfils this as does DBT in a less universal way. However, Mindfulness itself (outside of its ACT conceptualisation) does not originate as a concept within behaviourism. Equally, apart from at the superficial level of skills training CFT equally does not fulfil these criteria.

The Rediscovery of Emotion?

It is probably fair to say, that although not a defining characteristic, 3rd Wave has seen the rediscovery of emotion within CBT as a focus rather than simply the effect of cognition. The readiness of ACT and Mindfulness to address emotion directly, the very language of Compassion Focused Therapy with its interest in shame and self-soothing and the key role of distress intolerance within DBT, all point to an increased readiness in 3rd wave therapies to talk about and directly address feelings.

So what does define 3rd Wave CBT? As a heterogeneous set of therapies there is no clear conceptual bond that binds them together. They come from different traditions. However, rather than looking for a conceptual link, it may simply be easier to identify a linking intervention that they all share in common. That intervention may be conceptualised in different ways both in terms of its function and the mechanism it uses. However, it does not detract from the central unifying role it plays. That linking intervention is Mindfulness.

Mindfulness?

Whether Mindfulness is conceptualised as the compassionate mind, an attentional technique or as a strategy to facilitate cognitive defusion, it plays a central role in all 3rd Wave Approaches.
What follows is a brief outline of the theoretical foundations for each of a number of third wave therapies; the clinical application of these; and their effectiveness based on their current evidence-base.

Where possible, comparisons will be made to either treatment as usual, or second wave cognitive behavioural methods, to allow direct comparisons between each individual third wave therapy, and to then derive whether collectively such third wave methods have a place in the treatment of mental health problems.

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Chapter 2

Mindfulness

Mindfulness can be understood as an awareness that is gained from paying deliberate, and non-judgemental, attention to the present moment (Williams et al., 2007.) Mindfulness has received particular interest because it offers an alternative to established therapeutic models, through its focus of accepting symptoms that are difficult, or impossible to change. It can therefore be seen as offering something new to clients that other therapeutic models arguably do not provide (Teasdale et al., 1995).

Mindfulness-based stress reduction (MBSR) is a structured group programmes that incorporates mindfulness meditation to try to reduce symptoms of mental health problems. Participants are encouraged to accept with a non-judgemental attitude the difficulties they are experiencing, including their pain, difficult sensations, emotions, thoughts and behaviour (Fjorback et al., 2011). As such, MBSR has been shown to reduce levels of stress, depression and anxiety (Hoffman et al., 2011).

Mindfulness-based cognitive therapy (MBCT) developed, as an adaptation of the MBSR programme, specifically for clients with recurrent episodes of depression, to prevent them from experiencing a relapse of their symptoms. This is believed to take place through greater awareness, and disengagement, of negative thinking about a person’s own depressive symptoms (Segal et al., 2002). MBCT therefore incorporates selected elements from CBT for depression through the clinical application of mindfulness meditation (Segal et al., 2013). These include psychoeducation about the functions of thought processes in depression, and the roles that interplay emotions, thoughts and behaviour in maintaining depressive symptoms (Van der Velden et al., 2015). MBCT is subsequently recommended as a treatment for depression by the National Institute for Clinical Excellence (NICE, 2009). MBCT typically takes place over eight-weekly group sessions, an all-day silent retreat with individual daily homework in between the sessions.
Because MBSR can be seen as focusing more on the physical symptoms of stress, and has been shown to be beneficial to clients with cancer, chronic pain, heart disease and fibromyalgia, whereas MBCT is understood as focusing more on the cognitive aspects that have been shown to be integral to treating depression (Gotink et al., 2015).

**What are the Mechanisms for Mindfulness?**

How does Mindfulness actually work? The question of mechanism has been addressed far less frequently in the literature than the question of outcome. There are however a number of current suggested mechanisms that may underlie the effectiveness of Mindfulness.

It has obviously been argued ever since the creation of MBSR that Mindfulness’ effectiveness is based on the non-judgemental and non-reactive acceptance of all experience. However, it is still unclear why such non-judgemental and non-reactive acceptance should make so much difference to an individual’s emotional state.

With specific reference to relapse prevention in depression, Segal et al (2002) suggest that Mindfulness enhances of a cognitive awareness which facilitates disengagement from repetitive negative thinking (which might lead to subsequent depressive symptoms).

Williams et al (2000) has suggested that Mindfulness may work through a memory mechanism. Depressed clients often have problems with AMS or autobiographical memory specificity. This is the tendency to both remember and retrieve events related to self in global rather than specific terms. For example, when I fail a test, I both encode that as “I am a failure” (rather than “I failed that particular test”) and when I come to remember it I equally retrieve it as “I am a failure”. Williams suggests that through its non-judgemental attentional process, Mindfulness facilitates a greater memory specificity (both in encoding and in retrieval) and counteracts the natural process of suppression of unpleasant memories.
Both Brown et al. (2007) and Grabovac et al. (2011) have developed multifactorial models of Mindfulness that have also incorporated the mechanism of non-attachment to explain Mindfulness’ mechanism of effectiveness. This mechanism is clearly similar to concepts like “letting go” or “cognitive defusion” within ACT.

Grabovac et al (2011) also suggested that Mindfulness’ effectiveness also facilitated by its development of compassion within the client which acted as an antidote to the “formation of mental states that have their origin in aversion.” Within cognitive and behavioural theory this suggests that Mindfulness may be effective through the way it counters avoidance or safety behaviours than not only create problems but frequently maintain them as well. This compassion role clearly overlaps with proposed therapeutic mechanisms within Compassion Focused Cognitive Therapy.

A recent systematic review by Van Der Velden, et al., 2015, looking at the mechanisms of change of MBCT revealed that mindfulness, rumination, worry, compassion and meta-awareness mediated MBCT’s effect on the treatment outcome. In other words, the therapeutic benefits from MBCT can be attributed to their focus on the above mentioned factors. These results have been replicated by a systematic review and meta-analysis carried out by Gu et al. (2015), though their findings showed cognitive and emotional reactivity to be the strongest mediators, and moderate evidence for mindfulness, worry and rumination as mediators, though there insufficient evidence for the roles of self-compassion and psychological flexibility as mediators in MBCT. These two reviews therefore provide additional understanding of the mechanisms within MBCT that influence therapeutic benefits observed in reducing mental health difficulties.

The Evidence base

A systematic review of RCTs that use MBSR carried out to look at the potential benefits it offers in improving mental health in clinical and non-clinical populations. This review by Fjorback et al. (2011) included studies that have utilised MBSR for clients with cancer, chronic back pain, HIV,
rheumatoid arthritis and fibromyalgia. In these studies, there is support that MBSR can improve mental health through the reduction of symptoms of distress, anxiety and depression. The authors conclude that it is unclear whether their physical health improvements also came from MBSR.

Khoury et al. (2015) also carried out a meta-analysis investigating the effectiveness of MBSR, but only included studies based on a non-clinical population. Their findings showed that even though a clinical population was not targeted, there were moderate effects observed in clinical measures including depression, anxiety and distress, alongside a large reduction in stress and a substantial increase in quality of life.

As mentioned, MBCT adopts strategies used within MBSR, and developed specifically for clients who have experienced recurrent episodes of depression, with the aim to prevent the likelihood of them experiencing a relapse in symptoms. As such, there has been a lot of support for the effectiveness of MBCT in reducing depressive symptoms and preventing relapse.

A systematic review and meta-analysis that only included RCTs was carried out by Galante et al. (2012), and reported that in the eleven studies included in the review, MBCT reduced the rate of relapse in clients with three or more previous episodes of depression by 40% after a one-year follow-up. It is important to note though that authors did not find statistically significant differences between MBCT and TAU with clients who had two episodes of depression at one year follow-up. In other words, MBCT is shown to be effective in people who have three or more previous episodes of depression, and this review did not show that it is not effective in preventing relapse in people with two episodes or less. These findings have been supported by the understanding that people who have experienced multiple episodes of depression become more sensitive to triggers that might produce another depressive episode, and it is therefore less necessary for a stressful stimulus to produce a relapse. In other words, important stressful life events are not required to trigger another depressive episode, and as such MBCT techniques are useful and able to
prevent this oversensitivity from bringing about further episodes of depression.

There are some shortcomings however that have been pointed out within the current evidence base for MBCT. Though there are some trials to demonstrate the potential benefits of preventing relapse in depressed clients, studies utilising MBCT have only been compared against TAU, and so it is not clear whether there are any special effects that MBCT has precipitated which have caused such improvements (Coelho et al., 2007).

Evidence indicating the prospective benefits of MBCT in treating other mental health problems has been developing however. There is some preliminary evidence suggesting that MBCT can also be effective in reducing anxiety symptoms among clients with generalise anxiety disorder (e.g. Evans et al., 2008) and social anxiety disorder (Norton et al., 2015).

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Chapter 3
Acceptance and Commitment Therapy

Theoretical roots

ACT can be understood as a therapeutic approach that combines acceptance & mindfulness processes with Commitment and behaviour change processes to produce greater ‘psychological flexibility’ (Hayes et al., 2004).

According to ACT, events can be seen as ongoing actions within a specific context, and as such behaviour is understood with regards to contextual variables.

Thoughts can be understood as being useful in obtaining a more valued life, instead of being seen as correct or incorrect. As such, because thoughts (or private events) do not cause other behaviours, it is not necessary to change the content of them (Ruiz, 2010). The goals of ACT are prediction and influence, and as such, every behaviour should be explained in terms of contextual variables, otherwise it could not be influenced.

The ACT model can therefore be seen as focussing on awareness and a non-judgemental acceptance of all experiences, positive and negative, while also encouraging the identification of valued life directions, and subsequently setting appropriate goals that support those values (Hayes, Strosahl & Wilson, 1999).

These principles involve producing psychological flexibility, and the ability to become present in the moment more fully, and to either change or persist in behaviour that serves the person’s values (Hayes et al., 2006). In other words, psychological wellbeing is purported to be reflected by an individual’s ability to respond adaptively to ever-changing environmental situations.
In this light, the ACT model describes psychological *inflexibility* to be the result of ‘cognitive fusion’ and ‘experiential avoidance’ (Gaudiano, 2011). The former can be defined as a tendency to understand the world through the use of literal language. For example, an individual fused with the thought “I am depressed” is experiencing the thought literally; “I” = “depression”. This cognitive fusion is likely to dominate a person’s life, such that they might be then prone to thinking “I cannot go to work today because I am depressed” (Gaudiano, 2011). This natural language process is the focus of experiential avoidance, describing a pattern that is then exacerbated by our culture into a general focus on always trying to feeling positive and avoiding upset. The repercussions of avoiding uncomfortable events unfortunately tends to be an increase their functional importance, as they become more salient; while the very efforts used to control them become linked to negative outcomes, subsequently narrowing the number of behaviours available to the person, since many of such behaviours evoke these feared private events (Hayes et al., 2006). Such psychological inflexibility can be seen as problematic then, as it restricts the individual’s possible behaviours, and opportunities for reinforcement. This in turn can then lead to a lower quality of life (Bluett et al., 2014), and the person not meeting their desired values.

Within the ACT model, psychological flexibility is posited to be established through six core processes, where each process is conceptualised as a positive psychological skill, rather than a utility for preventing mental health problems. It is beyond the scope here to describe each of these processes in any detail (see Hayes et al., 2006. for a review), but they consist of: acceptance, contact with the present moment, values, committed action, perceiving the self as context, and defusion.

Öst (2014) conducted a literature search in the database PsychINFO using ‘acceptance and commitment therapy’ as the search terms, which yielded 78 hits from 2000 – 2004; 309 hits from 2005 – 2009; and 500 hits from 2010 – 2014, demonstrating a year-on-year increase in randomised controlled trials being carried out.
Evidence-base

The application of ACT in the treatment of mental health problems is broad and diverse, being used to treat people with varying difficulties including eating disorders, depression, anxiety, borderline personality disorder, substance misuse and chronic pain. The aim here is to present some of the evidence for the efficacy of ACT in the treatment of these varying mental health difficulties, alongside the conclusions derived from the existing systematic reviews and meta-analyses.

Depression

The first randomised controlled trials investigated the efficacy for ACT for treating depressed clients. These were conducted by researchers such as Zettle, Hayes and Rains in 1986 and 1989. The first study compared an initial version of ACT entitled Comprehensive Distancing, which took place over 12 sessions, to two versions of Beck’s Cognitive Therapy (CT). Here, ACT was found to be superior to the two version of CT in the reduction of depressive symptoms. Comprehensive distancing can be seen as trying to encourage the client to shift the focus of their private events (i.e. negative thoughts and feelings) and to understand the social context with which they are in. To date however, very few RCTs have been conducted to investigate treatment outcomes in the effectiveness of ACT in treating depressed clients.

A further two studies have compared ACT to treatment as usual (TAU) in the treatment of depression. Hayes et al. (2011) conducted a pilot study comparing ACT to TAU in treating adolescents with depression which showed a statistically significant difference in symptom reduction in favour of ACT. Another study by Folke et al. (2012) compared ACT to a control treatment in treating people on long-term sick leave due to depression, showing that after 18-months participants who underwent ACT had significantly improved on measures of depression, general health and quality of life compared to controls. There were no differences however in sick leave or employment status at any point.
A recent systematic review and meta-analysis by Ruiz, 2012 compared ACT with traditional CBT in the treatment of depression and showed them both to be equally efficacious. The evidence of how they operated however via purported processes of change was greater for ACT. Ost in 2014 has raised some general methodological concerns with trials investigating the efficacy of ACT.

In the last two years, ACT has been compared to CBT in treating depression by the U.S. Veterans Health Administration, showing that a 12-16 session ACT protocol reduced BDI scores from the severe to the mild range (Walser et al., 2013), showing a similar effect size to controlled trials of ACT, as well as those reported for traditional CBT in this veterans program. It should be noted however that the primary objective for ACT for depression is not merely symptom reduction, but rather to enhance valued living (Zettle, 2015).

There is also evidence that similar to computerised CBT (cCBT), ACT can be delivered without the facilitation of a therapist and still remain to be effective at treating depressive symptoms. One 2014 study with randomised outpatients with mild depressive symptoms offered either face-to-face ACT or a guided self-help treatment delivered on the internet. This consisted of two assessment sessions (pre and post) and an ACT-based internet program (iACT). The findings showed that the iACT intervention could be seen as effective as face-to-face ACT for outpatients with mild depressive symptoms.

It is clear that more RCTs are required to compare treatment outcomes for ACT in reducing symptoms among depressed clients. There are however a host of studies that have consistently shown a strong correlation between experiential avoidance (measured using the Acceptance and Action Questionnaire) and levels of depression (measured using the Beck Depression Inventory) (e.g. Bond & Bunce, 2000; Gold et al., 2007). This would therefore indicate an association between the theoretical focus of ACT and depression symptomology, though more studies are required to examine the role of ACT in isolation, or in combination with other methods, in treating depressed clients.
Anxiety

There is mixed evidence for the efficacy of ACT in treating various anxiety-related symptoms (see Bluett et al., 2014 for a review). It is beyond the scope here to detail studies in great depth, but studies have been carried out in clients with generalised anxiety disorder (GAD), post-traumatic stress disorder (PTSD), social phobia/anxiety, panic disorder, and obsessive compulsive disorder (OCD).

A small number of studies have shown that ACT can reduce generalised anxiety symptoms with perhaps the most promising study showing that compared to a clients on a waiting list, clients who received ACT experienced significant reductions in anxiety symptoms from pre to post, and at 9-month follow-up 77% no longer met the criteria for GAD, while only 17% of those on the waiting list did not meet criteria any more (Roemer et al., 2008).

Studies of ACT for PTSD are in their infancy, though a few case studies for adults have been able to show that ACT has been helpful treating distress, depression and anxiety, but more RCTs are required.

A study giving clients with social anxiety 12 weekly individual sessions of ACT showed significant reductions in severity of their social phobia and anxiety symptoms post-treatment (Dalrymple & Herbert, 2007).

There are only two published studies to date that use ACT in treating people with panic disorder. One study showed that people with panic disorder, with and without agoraphobia, experienced a significant reduction in anxiety sensitivity, agoraphobic cognitions, and a significant increase in mindfulness, after four sessions of ACT, and six sessions on exposure therapy presented from an ACT theoretical model (Meuret et al., 2012). A case study implementing 12 sessions of ACT showed similar findings (Lopez, 2000).

Finally, there is currently only one RCT examining the use of ACT in treating OCD, when compared to progressive relaxation training, demonstrating a
greater reduction in OCD severity in favour of the ACT treatment (Twohig et al., 2010).

Overall, the results of preliminary meta-analyses indicate show that ACT is equally effective as other manualised treatments, such as CBT, in reducing anxiety-related symptoms (Bluett et al., 2014).

Other mental health problems

It is beyond the scope of this paper to detail the effectiveness of ACT among all mental health problems, but a brief outline shows that there are a few studies showing that ACT is superior to TAU in reducing psychotic symptoms (Gaudiano & Herbert, 2006), and has helped to improve psychological flexibility and emotion regulation skills among clients with borderline personality disorder (Morton et al., 2012). The general consensus is that more RCTs are required, as many of the current findings have been obtained from pilot studies with small samples. There are also several studies that show ACT to be effective in treating clients experiencing in chronic pain (Thorsell et al., 2011), fibromyalgia (Wicksell et al., 2013), and chronic pain with whiplash (Wicksell et al., 2008).

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Chapter 4
Compassion Focused Therapy

Theoretical roots
Compassion Focused Therapy (CFT) can be understood as being initially developed to help people experiencing complex mental health problems linked to higher levels of shame and self-criticism (Gilbert, 2009). The theoretical roots of CFT incorporate evidence from neuropsychology, attachment theory, evolutionary psychology, social psychology and Buddhism (Gilbert, 2014).

From an evolutionary perspective, CFT focuses on three main evolved functions of emotions; 1) an alertness to threats, and to subsequently activate defensive coping strategies; 2) to provide information on the resources and rewards available and to then activate engagement-seeking strategies; and 3) to think about safe places, that allow rest and non-action in the form of contentment and openness (Gilbert, 2014). As such, CFT has adopted a three system approach that regulates emotions in individuals based on this evolutionary theory.

The threat-protection system provides the individual with the ability to detect and respond to threatening situations appropriately (Le Doux, 1998). Within this system, the individual might experience feelings of anger, anxiety and disgust, producing what seems to be a negativity bias that can be seen to be central to human survival – that is, individuals tend to pay greater attention to, and remember more easily, negative more so than positive events (Baumeister et al., 2001). This system can therefore be seen as safety seeking and protecting the individual.

The second system often termed the seeking and acquisition system is associated with seeking propriety and wellbeing, through the gaining of resources. It is this system that strives for positive feelings throughout attaining success. Conversely, such overreliance on achievement and
acquiring can make individuals more vulnerable to feelings of depression, when motivates get blocked, or are not successful (Taylor et al., 2011).

The third system, known as the *safeness and contentment system* is not based on any activation, threat or achievement, but instead focuses on feeling safe, through calming and soothing, and just generally feeling content. This could be understood as a mindfulness system, by encouraging people to access the so-called ‘being mode’ rather than the ‘doing mode’.

In practice, CFT aims to enable clients to develop self-compassion, compassion towards others, as well as openness to compassion from others (Leaviss & Uttley, 2015). Cognitive behavioural principles are also incorporated into therapy, such that the therapist is likely to develop a case formulation and a treatment plan when working with clients (Beaumont & Hollins-Martin, 2015). Also during the course of CFT clients are taught the use of compassionate mind training (CMT), which enables clients to develop the key attributes of compassion for self and others, distress tolerance and non-judgement (Gilbert, 2009). These methods and techniques used in CFT will be detailed further, before consideration is given to their clinical effectiveness in relieving mental health problems. Individuals are encouraged to use self-soothing techniques, while the therapist acknowledges and validates clients’ feelings, by listening warmly to them (Gilbert et al., 2004). Some techniques encourage the therapist to include imagery, compassionate thinking towards the self and others and the use of self-compassion to respond to self-criticism, often coupled with compassionate letter writing (Leaviss & Uttley, 2015).

Imagery is a technique that has been adopted by many therapies, by which clients can envisage more positive places, people or activities. Lee (2012) has described various strategies that adopt these methods, including the ‘perfect nurturer’. Using this strategy, clients are encouraged to think of an ideal person, who in their eyes could be seen as the perfect person, who will be calming, reassuring, sympathetic etc, and generally possess the ideal qualities that the person really wants. Another commonly used imagery technique used within CFT is the development of a safe place that the person is able to envisage when they are feeling distressed. This could be of
an actual place that they have visited, or of somewhere they have seen in photographs, that for them would be somewhere calming and relaxing. The person can also create a safe place in their own home, somewhere that is comforting, with their favourite views, on the sofa, with a soft blanket, a warm beverage, listening to their favourite music or looking through pictures that conjure up happy memories, for example.

The goals of CFT can therefore be seen to ameliorate feelings of shame and self-criticism, through the practice of self-compassionate behaviours. Some have argued that individuals with a critical ‘inner voice; may struggle to engage with other evidence-based therapies. Hence helping the individual be more self-compassionate may enable better therapeutic engagement with other modalities as well (Leaviss & Uttley, 2015). CFT has therefore been proposed to be utilised as a multi-modal therapy, and to be incorporated with other therapies, rather than as belonging to a single ‘school of therapy’.

Overall, CFT delivers psychoeducation that focuses on qualities of self-compassion, understanding self-criticisms as safety behaviours, and to develop empathy for one’s distress. And then as a result, re-focus on images, thoughts, emotions and behaviours that bring about such compassion (Gilbert & Proctor, 2006). Furthermore, shame, self-criticism and hostility towards the self can be seen as transdiagnostic difficulties which operate across various mental health problems (Gilbert, 2014). CFT will be often used in conjunction with other evidence-based interventions that have been shown to be effective for any particular problem.

Evidence base

In recent years there has been a growing plethora of research indicating that developing feelings of compassion, both for self and others, can have a profound impact on individuals’ mental health (Harman & Lee, 2010).

Individuals with high levels of shame and self-criticism often come from backgrounds where there were greater levels of neglect, or even
experiences of trauma, and have thus rarely felt comforted, safe or reassured (Leaviss & Uttley, 2015). Increases in self-compassion have been shown to be associated with a reduction in psychiatric symptoms and interpersonal problems (Schanche et al., 2011). Such evidence indicates that self-compassion is associated with psychological wellbeing, and that it might be a better predictor of anxiety and depression than mindfulness, though this does not infer a causal relationship between self-compassion and wellbeing (Van Dam et al. 2011).

There is not a large evidence-base for the efficacy of CFT in treating mental health problems, but there is reason to believe it can be effective in reducing symptoms relating to low self-esteem, and in particular building self-compassion in individuals with low self-esteem. In many individuals who present with low self-compassion, there is often a fear of receiving compassion that runs in parallel, and feelings of warmth or gentle reassurance can appear frightening. One study Kelley et al., 2014, investigating self-compassion in clients with an eating disorder showed that fears of self-compassion to be a strong predictor of eating disorder pathology. Hence building self-compassion might act as a valuable approach for preventing eating disorders in young females.

Adaptations have been made to CFT for people with eating disorders, entitled compassion-focused therapy for eating disorder (CFT-E). This new, adapted model proposes that the current treatment efficacy for eating disorders is limited for clients who are unable to activate and use their soothing systems, and behave compassionate towards themselves (Goss & Allan, 2014). Given how recent this adaptation is to eating disorders research, there is only preliminary evidence available at present demonstrating its effectiveness. What evidence that is available however does indicate it to be effective at reducing symptomology in people with eating disorders (Gale et al., 2014).

There is also increasing evidence for the effectiveness of CFT with other mental health problems. Preliminary studies such as Johnson et al in 2011 have shown that clients with psychosis have experienced significant improvements following CFT treatment. In one study, clients with a
diagnosis of schizophrenia-spectrum disorder were randomised to receive either CFT plus TAU, or TAU alone. Clients who received CFT showed significantly greater improvements in levels of compassion, as well as reductions in depression and perceived social marginalisation. Braehler et al 2012 also found that these clients also had low attrition to the intervention. Finally there is also some preliminary evidence by Lucre & Corton in 2013 that CFT can reduce symptoms of shame and self-hatred in people with personality disorders.

The general consensus from the current literature-base appears to show the effectiveness of CFT in being able to reduce levels of shame and self-criticism, while also creating improvements in self-compassion, in individuals with various mental health problems. Though research is still in its infancy for CFT, there is good reason to believe that it is beneficial in conjunction with other evidence-based therapies.

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Chapter 5
Dialectical Behaviour Therapy

Theoretical roots

DBT is a cognitive-behavioural treatment model that originally developed to treat individuals, mostly women, with chronic suicidal ideation and who meet the criteria for borderline personality disorder (BPD) (Neacsiu, Rizvi, & Linehan, 2010). Historically, BPD has been difficult to treat, and has been associated with poor treatment outcomes (Choi-Kain, & Gunderson, 2009). Within the DBT framework, individuals with BPD are considered to be self-destructive due to deficits in interpersonal, self-regulation and distress tolerance skills (Dimeff & Linehan, 2001).

The focuses of DBT can be understood as targeting specific maladaptive behaviour patterns through four modules. These include: 1) reducing suicidal and parasuicidal thoughts/actions; 2) decreasing behaviours that interfere with therapy, such as excessive phone calls made to the therapist, and leaving therapy prematurely; 3) to reduce behaviours that interfere with their quality of life, such as substance abuse; and 4) to increase behavioural skills, through emotional regulation, self-management and mindfulness (Linehan et al., 1994).

The aim can therefore be seen as providing individuals with the necessary skills to handle emotional dysregulation, such that they do not feel as though they need to carry out self-injurious behaviour, or engage in suicidal ideation.

DBT was originally designed to be delivered through an outpatient treatment program, and is considered to be an intensive procedure. This typically consists of one year of weekly sessions of individual psychotherapy which focuses on increasing motivation; one year of weekly group skills training; phone consultations with the therapist as needed to assist skill and motivational difficulties common in people with BPD; alongside weekly team meetings for DBT therapists to enhance their own capabilities and
motivation in order to provide the most effective treatment (Linehan, 1993). DBT has also been introduced into inpatient settings, as well as developing short alternatives, and these will be detailed further later.

**Evidence base**

Given that DBT was specifically designed to treat maladaptive behaviour patterns in people with a BPD, there is a strong bias in the number of studies and RCTs investigating the effectiveness of DBT in treating mental health problems in favour of BPD. I’ll present the evidence base for DBT in the treatment of BPD, before consideration will be given to attempts that have been made to incorporate DBT into the treatments of other mental health difficulties.

In one of the earliest RCTs to be carried out investigating the effectiveness of DBT in the treatment of BPD, participants either randomised to receive one year of DBT, or TAU which may or may not have included individual psychotherapy. The results showed that throughout the one-year follow-up, participants who received DBT scored much higher on global functioning, while during the initial six-month follow-up, DBT participants displayed significantly less parasuicidal behaviours and anger. During the final six months, DBT participants had significantly fewer days as psychiatric inpatients (Linehan et al., 1993). These findings have been substantially replicated by several authors, who have also found that women with BPD who undergo 12-months of DBT have better retention rates, and greater reductions in self-mutilating and self-damaging impulsive behaviours than those who received TAU (Verheul et al., 2003).

A systematic review and meta-analysis examining the five RCTs that have utilised DBT in people with BPD have shown it to be consistently efficacious, such that it can significantly decrease suicidal and self-harming acts (Panos et al., 2014). This review however did note that although there are some improvements in so-called therapy interfering behaviours, these not statistically significant. There is however some evidence that shows DBT is effective at treating people with depression and personality disorder.
However, it is clear that this level of investigation is still in its infancy. Some have posited however that the effectiveness of DBT in improving emotional dysregulation symptoms in BPD, (a feature that is also common in other mental health problems), might mean there are other clients who might benefit from DBT.

Given that the 12-month course of DBT can be seen as intensive, both for clients and for therapist, there have been attempts at delivering DBT to groups, to see if it can produce similar levels of efficacy to those previously reported using the conventional DBT approach of individual psychotherapy combined with skills groups. A study conducted by Gutteling et al. (2012) was the first attempt at carrying out 12-months of DBT group therapy in an outpatient setting with people who had a diagnosis of BPD. This was to investigate whether this can be as efficacious as standard DBT methods. The authors found that a statistically significant reduction in depressive symptoms, suicidal thoughts, anxiety and anger. Hence outpatient group DBT appears to be as effective in reducing psychiatric complaints as the original DBT treatment model.

Attempts have also been made to incorporate DBT into treatment for clients within inpatient settings, to see if similar outcomes can be observed as those observed in studies of 12-month outpatient programmes (e.g. Bohus et al., 2000; Bohus et al., 2004). In these studies, participants engaged in a 3-month inpatient DBT treatment programme, which reduced global symptoms, depression, anxiety, dissociative experiences and self-mutilating behaviours. Following on from these findings, Kroeger et al. (2006) conducted a similar study, where inpatients who met the criteria for BPD, (but who also had other comorbidities), received a 3-month DBT programme. The findings from this study showed at discharge and at 15-month follow-up, that clients experienced a significant reduction in psychopathology. The effect sizes were similar to those of previous studies. These studies have therefore shown that traditional DBT methods can be adopted and utilised in inpatient settings with similar outcomes to those reported in outpatient settings. Furthermore, a systematic review of the
literature of DBT within inpatient settings shows that it to be effective at reducing symptoms related to BPD (Bloom et al., 2012).

There have also been attempts at providing shortened versions of DBT. Most notably, the DBT skills training groups have received particular attention, when provided with other aspects of the treatment, including mindfulness, emotional regulation, distress tolerance and interpersonal effectiveness skills. One such study examining the Living Through Distress programme – a DBT-informed skills group for people who engage in deliberate self-harm, AND who are currently in an inpatient setting. This programme provides an hour of skills training four days a week, over six weeks. The aim is to provide with clients with the necessary skills to help them to cope when experiencing intense emotional distress, rather than engage in self-harming behaviours. The results of this study showed that clients who underwent this programme had greater reductions in the frequency of deliberate self-harm, while also reporting improvements in some aspects of emotional regulation. This was when they were compared to clients receiving TAU. These improvements also maintained at 3-month follow-up according to Gibson et al., 2014.

A systematic review carried out by Valentine et al. (2015) looked at the evidence base for the effectiveness of the shortened DBT skills training in treating other common in mental health problems. The authors observed consistent reductions in depressive symptoms in studies that compared DBT against a comparison group who remained on the waiting list for treatment. Similar findings have been observed also when DBT has been compared to TAU. This review also identified five studies which examined the effectiveness of DBT skills training in people with binge eating behaviours. The authors of these studies report that improvements in emotional regulation, one of the facets of DBT, is likely to be the driving influence in reductions in binge eating behaviours in these samples (e.g. Telch et al, 2001).

Overall, the evidence supporting the role of DBT in reducing suicidal ideation, self-injurious behaviours, and improving emotional dysregulation in clients with BPD, is strong. The National Institute for Health and Clinical
Excellence recommends the use of DBT for women with borderline personality disorder (NICE, 2015.) There is also some indication that DBT is useful in improving depressive and anxiety symptoms, though further research is required to determine the precise mechanisms of change, or whether this is merely due to the focus DBT has on emotional regulation skills. There have also been successful attempts at producing shorter versions of DBT in outclient settings, while also introducing these into inclient settings. Given that DBT developed specifically for people with self-destructive behaviour patterns, it is important to consider its application to other mental health problems.

Other mental health problems

The research of DBT and its application to other mental health problems is very much in its infancy, but some examples of its application will be outlined here. Given the similarities between BPD and bipolar disorder, with regards to emotional dysregulation, impulsivity, and suicidal ideation, some researchers have investigated the effectiveness of DBT in clients with bipolar disorder. One study utilised DBT in treating adolescents of bipolar disorder, whereby clients received six months of weekly sessions of family skills training and individual therapy, followed by twelve additional sessions throughout another year. Clients reported a significant improvement with regards to suicidal ideation, self-injurious behaviour, emotional dysregulation and depressive symptoms (Goldstein et al., 2007). Another study randomised clients with a diagnosis of either bipolar I or bipolar II to receive the DBT intervention or remain on the waiting list. The DBT intervention consisted of twelve weekly sessions that focused on DBT skills, mindfulness techniques and general psychoeducation. As a result, Van Dijk et al (2012) demonstrated that clients who received the intervention experienced a reduction in depressive symptoms, and improvements in affective control and mindfulness self-efficacy.
Bankoff et al (2012)’s systematic review of DBT found clear evidence of its effectiveness with working with Eating Disorders, although the mechanism for this is unclear as expected gains in emotional regulation did not occur.

Beckstead et al (2015) recent study on the use of DBT with over 200 adolescents with substance misuse problems found that 96% demonstrated clinically significant gains with large positive effect sizes.

Frazier & Velanine (2014) examined 9 randomized controlled trials (RCT) specifically assessing the impact of DBT in reducing anger and aggressive behaviour. These clients significantly were represented in offender populations within the justice system. Again they found clinically significant results.

This work, although not as established as DBT with BPD, points in the general direction of conceptualising DBT as an intervention of choice with “Difficult to Treat”, Unmotivated or Resistant client groups.

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Chapter 6

Summary

Third wave therapies developed with a variety of additional foci – over and beyond those contained within second wave CBT therapies.

They focus on improving the quality of clients’ lives, rather than merely reducing the severity, or presence, of their mental health difficulties.

They all incorporate mindfulness techniques within the therapeutic process – whether it is through the use of the concept of compassion or through the concept of flexible attention and acceptance.

Mindfulness was developed for the purpose of reducing relapses among clients with previous episodes of depression, and the evidence base thus far indicates it to be effective at achieving this in people who have has three or more previous episodes of depression. Mindfulness techniques more generally have been shown to reduce general symptoms of stress, depression and anxiety in non-clinical populations, while also improving quality of life.

The core processes in ACT focus on improve clients’ psychological flexibility, by understanding the contexts surrounding their distressing private events, rather than merely trying to change their core thinking patterns. Symptomatically, there is a good evidence base demonstrating ACT to be effective at reducing depression and anxiety symptoms. However, it is clear that further research is required to better understand the mechanisms that mediate the purported effectiveness of ACT in these clinical populations.

The development of CFT has encouraged people with greater levels of shame and self-criticism to adopt soothing techniques to help them to adopt a more accepting and positive attitude towards themselves. The evidence base for CFT suggests it is particularly effective at improving clients’ levels of self-compassion, fears of compassion, shame and self-criticism with a range of mental health problems. CFT appears to be best
utilised in conjunction with other evidence based therapeutic models specific to the particular mental health problem being addressed.

DBT developed with the specific intention of treating people with suicidal ideation and self-injurious behaviours, who have difficulties in regulating their emotions, which subsequently lead to them to engage in harmful coping strategies. Again, there is a strong evidence base for DBT, and its effectiveness in reducing harmful behaviours in individuals with BPD, alongside other mental health problems for which clients’ exhibit self-harming behaviours and suicidal ideation.

As mentioned, a common focus among the third wave therapies reviewed here is that of empowering individuals to living a meaningful life that is positive, rather than merely being symptom-free. Indeed, though there is this commonality, each therapy, outlined here, developed with its own unique focus. For example, DBT focuses on reducing maladaptive behaviours, CFT on addressing feelings of shame and self-criticism.

Each third wave therapy outlined is very much in its infancy. Although DBT and Mindfulness already have a strong evidence base for their clinical effectiveness, their applicability to other mental health problems is very much in its early stages of investigation. However, their promise is striking, their practicality already demonstrated and their future already established.

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