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Book Reviews

The Oxford Guide to Behavioural Experiments in Cognitive Therapy
Oxford: Oxford University Press, 2004. pp. 482. £29.95 (pb). ISBN 0-198-52916-3.
doi:10.1017/S1352465805212298

The behavioural experiment is arguably the most effective technique within cognitive therapy. Yet it requires a good collaborative relationship, creativity and discipline to carry them out consistently and effectively. The publication of *The Oxford Guide to Behavioural Experiments in Cognitive Therapy* is likely to cause a quantum shift in their use in clinical practice. All of the authors of this edited book are members of, or have direct links with the world-leading Oxford Cognitive Therapy Centre. The book begins with a scholarly yet accessible overview of the concept of the behavioural experiment, followed by a chapter providing a step-by-step description of how to construct them. It is encouraging to read the range of formats that can constitute a behavioural experiment, including surveys, role-plays and real-life situations. Experiments to test beliefs about the self, others and also mental processes and emotions can be created. One critical feature is to plan the experiment well so that the possible outcomes and their meanings are specified before the test, and therefore easily compared with what really happens. The main chapters of the book are divided by disorder or presenting problem. The anxiety disorders are each allocated a separate chapter, followed by depression, bipolar disorder, psychosis, eating disorders, insomnia, physical illness and disability and acquired brain injury. Four chapters on transdiagnostic issues follow: low self-esteem, avoidance of affect, interpersonal difficulties and self-injurious behaviours. Each chapter is structured in exactly the same way, making it ideal as a reference tool. First, the nature of the disorder or presenting problem is described, then the major cognitive models or theories are explained, followed by several examples of real behavioural experiments and the chapter is rounded off with important considerations. The book is made even more accessible and enjoyable to read by illustrations and humorous experiences that are peppered throughout the text. The contributions by David M. Clark and Christine Padesky ground the book firmly in both science and practice. Books like this are few and far between. It works as an accessible introduction to the practice of contemporary CBT, an overview of the most useful cognitive models of psychological disorders, and a unique reference book for finding out practical instructions and creative inspiration. You could divide therapy manuals into three categories: “non-directive” books that look nice just sitting quietly on your shelf, “cognitive books” that have useful insights but are rarely used, and finally true “cognitive-behaviour books” that are so good that you promptly test them out in practice. This book definitely belongs to the last category and will really influence clinicians’ behaviour.

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Early Detection and Cognitive Therapy for People at High Risk of Developing Psychosis: A Treatment Approach.

Paul French and Anthony P. Morrison

Chichester: John Wiley & Sons Ltd, 2004. pp. 146. £13.99 (pb). ISBN 0-470-86315-3.
doi:10.1017/S1352465805222294

This book provides an easy to read guide to clinicians working with individuals at ultra high risk (UHR) of developing psychotic disorders. Its content draws upon the experience of Paul French and Tony Morrison in working with UHR individuals as part of the Early Detection and Intervention Evaluation (EDIE) study, which evaluated the potential of cognitive therapy (CT) to prevent psychosis in this group. The results of this study were published in October 2004 in the *British Journal of Psychiatry*.

The authors make a strong case for intervention in the UHR population. They refer to the concept of a "critical period" during which interventions are most effective and make the point that the typical age of onset for psychotic disorders is during a period of life when people are consolidating social networks, studying for qualifications, beginning careers and starting families. The methods used to identify UHR individuals developed by pre-psychosis intervention services in Australia (PACE), Germany (Fetz) and the United States (PRIME) are briefly described. A helpful checklist for primary care clinicians is reproduced. They describe PACE and PRIME RCTs of low dose risperidone and olanzepine. They make a cogent argument against the use of antipsychotic medication in UHR individuals in favour of CT despite the fact that the PACE study of outcomes in UHR individuals demonstrated a significant benefit of adherence to antipsychotic medication regime (McGorry et al., 2002). The risk of side-effects and neuroleptic malignant syndrome is cited as a particular contra-indication and they emphasize the fact that, even without treatment, around 60–80% of UHR individuals would be expected not to develop psychosis.

The authors discuss the reasons why individual cognitive therapy was chosen over other forms of psychological therapy. They firmly prescribe a high degree of structure in CT for UHR individuals. The importance of developing a formulation based on a cognitive model is emphasized and Morrison's (2001) model is explained in lucid terms. They give some examples of the problems elicited from patients illustrating the fact that only a minority concern psychotic symptoms. Problems identified by UHR individuals are often related to anxiety or mood problems for which other cognitive models exist, yet these are not referred to by the authors. However, Morrison's (2001) model is derived from models of anxiety disorders and is flexible enough to incorporate non-psychotic symptoms.

Many UHR individuals are ambivalent about accessing services for fear of receiving a stigmatizing label. Practical considerations, such as avoiding secondary care settings and tolerating non-attendance are emphasized. The authors also advocate a willingness to provide case management and crisis management beyond that usually expected of a cognitive therapist. Specific consideration is given to the fact that at risk individuals tend to be young and to have had little previous contact with the mental health system. They raise the issue of referrals from secondary care services who are not directly help-seeking, suggesting an assertive outreach strategy. Although done with the best intentions, assertively pursuing UHR individuals raises ethical issues if they do not meet diagnostic criteria for a mental illness.

Specific recommendations for the assessment of UHR individuals include gathering information about social relationships that might provide normalizing interpretations of intrusions into awareness and the procedural beliefs that influence selection of information-processing

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strategies. They provide a client friendly adaptation of the model, along with other useful materials, in the book's appendices. However, they fail to address the two-stage process of assessment in this population. When individuals are referred to the service it is first necessary to establish whether they are UHR and rule out the presence, or history, of psychosis. This can lead to opposing agendas: to draw out the full extent of conviction, preoccupation and distress during intake assessment and to decrease conviction, preoccupation and distress by facilitating alternative interpretations during CT assessment.

The authors note that knowledge about the context in which unusual beliefs and perceptions develop influence clinicians' appraisals of their nature as psychotic or otherwise. They present evidence that worry about relapse, in those who have previously experience psychosis, increases the risk of relapse. They infer that a similar process is likely to occur in those who have not previously experienced psychosis and use case examples to illustrate thought-control strategies and safety behaviours that can drive this process. They recommend an extensive assessment of all the possible explanations that have been considered by or suggested to the individual. These explanations should be incorporated into a formulation that includes historical factors that might have led to such explanations and safety behaviours that maintain them. Having tested the evidence, a reformulation should be constructed. This process is summed up eloquently in a few pages with helpful case examples, prompts and resources.

French and Morrison suggest that appraising cognitive processes as evidence of impending madness is likely to increase the probability of psychotic experiences. However, there is an apparent contradiction with evidence for associations between positive beliefs about hallucinations and the frequency of hallucinatory experience, which they also cite. This is not fully explained. They recommend standard CT techniques to address metacognitive beliefs but stress that costs and benefits should be analysed before modification is considered. Similarly, the authors suggest that the modification of core beliefs is not always necessary to achieve clinical gains and recommend gaining consent from clients. French and Morrison list a variety of circumstances under which individuals might become isolated. Culturally unacceptable appraisals are more likely to occur when alternative explanations are not available. Social isolation decreases the availability of alternative explanations. They cite some examples of culturally unacceptable appraisals endorsed or suggested by others. A model is proposed to explain the way in which schema congruent misinterpretations lead to increased monitoring of external and internal events, which are then interpreted within that same framework leading to a vicious circle. Regarding relapse prevention, even individuals whose symptoms have never reached psychotic intensity are eager to avoid the distress that led them into contact with services. French and Morrison draw attention to McGlashan's (1987) assertion that individuals who "seal over" their experiences are more likely to relapse than those who integrate them. They cite the Gumley et al. (2003) model of relapse, which suggests that individuals monitor themselves in order to detect symptoms. If an exacerbation is detected and negatively appraised, the resultant emotion drives further exacerbation leading to a vicious circle.

Overall, this is an excellent introduction to the field of prevention of psychosis. It deals with the important issues without getting bogged down in theoretical debates. Its description of CT formulation and intervention is illuminating but concise. The liberal use of case examples, suggested rationales and other resources are particularly welcome.

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Cognitive Approaches to Obsessions and Compulsions: Theory, Assessment and Treatment

Randy O. Frost and Gail Steketee

New York: Pergamon, 2002. pp. 473. £68.12 (hb). ISBN: 0-08-043410-X.
doi:10.1017/S1352465805232290

This book has been written by various members of the Obsessive Compulsive Cognitions Working Group (OCCWG), a hugely influential international group interested in understanding the role of cognitive factors in obsessive compulsive disorder (OCD). It includes most of the world's leading experts in cognitive behavioural therapy for OCD, and is in essence a summing up of the discussions they have had, and work they have completed to move forward the treatment of OCD in the last 8 years.

There are five sections, and at the end of each there is an expert discussant who summarizes, which is particularly helpful. The sections cover the following areas: (1). Domains of belief in OCD. This contains five chapters giving definitions, description of the background theory, and state of measurement and research in the five main cognitive domains of OCD i.e. importance of thoughts, need to control thoughts, responsibility, overestimation of threat and intolerance of uncertainty and perfectionism. It recommends, and suggests further areas for research. (2). Measurement of cognitions in OCD. These chapters focus on the different measurement and experimental techniques that have been used to examine and evaluate different thinking styles thought to be relevant in the development and maintenance of OCD, particularly in the main cognitive domains. (3). Cognition in disorders related to OCD. This section includes chapters on cognitions in hoarding, eating disorders, body dysmorphic disorder, depression and schizophrenia. Discusses the relationship between OCD and these other disorders, and in particular the similarities/differences in the disorders and their cognitive styles. An interesting and helpful section, particularly in clarifying, differentiating and identifying key cognitive styles of each disorder. (4). Cognition in selected OCD populations. This includes chapters on cognition in children, the elderly, sub-clinical OCD, severe, treatment resistant OCD and cognitions across cultures. These chapters are particularly helpful for anyone working with these specialist groups. They highlight the need for further research in these areas, and focus on slight twists, additions and amendments that may be made to the general cognitive model of OCD to make it more effective for these particular groups of clients. (5). Therapy effects on cognition. This includes chapters on cognitive changes following exposure therapy, cognitive

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effects of CBT, group CBT, medication effects on obsessions and compulsions. I particularly enjoyed this section, and found it helpful in that it really does sum up some of the most relevant research in CBT for OCD, particularly the old chestnut of whether CT actually adds anything to BT, and the difficulties in truly testing it out. The group CBT chapter also gave some very helpful therapy examples and tips for dealing with certain aspects of OCD, and illustrated the approach very nicely. Additionally in the appendices are the Obsessional Beliefs Questionnaire and scoring guide.

In summary, this is an excellent book for anybody interested in CBT for OCD. As well as summing up all the pertinent theory and research, it gives some great suggestions for future research areas. It is nicely laid out, and easy to read. It includes quite exhaustive references, and feels very fresh and up to date. I particularly enjoyed having the depth of virtually all the experts in CBT for OCD in one volume. This made it easy to compare and contrast all the different models and methods there are when treating OCD, and also the slightly different views, ideas and emphases on differing aspects, all working within a CBT model. It did emphasize how creative it is possible to be, and certainly gave me some news ideas and ways of thinking about OCD. The one criticism I would have is that it did feel rather as though each chapter was a stand alone, and much of the background detail of the OCCWG was repeated.

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Obsessive Compulsive Disorder: Contemporary Issues in Treatment

Wayne K. Goodman, Matthew V. Rudorfer and Jack D. Maser

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On first glance, this is a rather daunting tome, and was not very attractive to me. It is broken down into seven sections, but would appear to be written more with the medical professional/researcher in mind, and there is much more emphasis on medical rather than psychological treatments. It certainly is not a therapy manual, and does not deal in any great detail with therapeutic strategies. It does, however, represent all the major psychological models, and provides up to date references and research.

This book covers an exhaustive range of contemporary issues in obsessive compulsive disorder (OCD), and in particular is valuable in concisely summing up the state of play in areas other than CBT, such as biological models, aetiology. I would say it is an essential reference/resource book for anyone who spends a lot of their time working with clients with OCD, as it is clearly desirable that all therapists, regardless of therapeutic orientation, should be at least as conversant in other competing theories/models, as our clients often are.

It covers an amazing breadth of subject matter, from co-morbidity, spectrum disorders, through to psychosurgery. Although it highlights the progress that has been made in OCD over the years, its main remit is to investigate treatment refractory OCD. The chapters are fairly short and to the point, and each is laden with high quality, up to date references, should you wish to pursue the area further. Sections include: Clinical Subtypes and Spectrums, Pathophysiology and Aetiology, Assessment, Cognitive Behavioural Treatments, Drug and Other Somatic Treatments, Combined Treatments and Mechanisms of Action. Most of the

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worldwide authorities on OCD are included, representing their many and varied viewpoints, which is very refreshing.

However, as a cognitive behaviour therapist I did find it rather discouraging to see that it was not clearly signposted, as in the NICE guidelines, that CBT is the first line treatment for OCD. I was saddened to read that some of the more harsh and invasive treatments did not seem to have any clear criteria as to under what circumstances the treatment should be considered, nor evidence of efficacy, or even clear criteria as to what constituted "treatment resistance". Whilst clearly CBT is not effective for everyone, and some of these treatments have their place, surely it is unfair to consider someone who has not even had CBT as treatment resistant? It would seem to be very important that any of the more invasive options are seen as last resort when the more familiar treatment pathways with OCD have failed. I was also particularly disappointed that the chapter on co-morbidity with schizophrenia was particularly medication management orientated. There was no mention at all of the encouraging developments in CBT for psychosis.

In summary, this is an essential reference book for any professional with a serious interest in OCD, particularly treatment-refractory OCD. It would be a good addition to any library. I would not recommend it for any one looking for therapeutic strategies.

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