Cognitive Behavioural Therapy Research Paper

Kelly Elker

University of Calgary

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Cognitive behavioural therapy (CBT) emerged from Aaron Beck’s research and development on Cognitive therapy (CT) in the 1960’s (Beck & Weishaar, 2014). The purpose of CBT is to adjust information processing and aims to assist client’s in identifying dysfunctional cognitions and behaviours and replace them with more adaptive ones (Chawathey & Ford, 2016).

As one of the most popular approaches to therapy, CBT education is crucial to those in the field psychotherapy. The purpose of this paper is to educate those individuals who are interested in using CBT in future practices. Basic concepts and assumptions, the counselling and treatment process, strengths and weaknesses of the therapy and future considerations will be explored.

**Philosophical Assumptions and Basic Concepts**

**View of Human Nature**

The view of human nature in CBT is based on the idea that for an organism to survive they must process relevant information from their environment (Beck & Weishaar, 2014). Cognitive schemas are structures composed of cognitive, behavioural, affective, and motivational systems an organism (Beck & Weishaar, 2014). Schemas contain people’s perceptions of themselves and others which control processing information (Beck & Weishaar, 2014). Human evolution and previous learning history influences an individual’s responses to all of life’s events and experiences (Beck & Weishaar, 2014).

**View of Distress and Emotional Disturbance**

Considering cognitive schemas influence and processing information, faulty cognitions and schemas also affect emotional disturbance and distress in humans. Faulty cognitions and making incorrect inferences between reality and fantasy can cause emotional distress (Corey, 2011). Impairments of normal cognitive activity, such as exaggerated cognitions, inability to turn off idiosyncratic thinking, and dysfunctional perceptions of reality all cause emotional distress (Beck & Weishaar, 2014). In addition, emotional distress can also be caused by biochemical predispositions to a variety of illnesses that cause faulty cognitions (Beck & Weishaar, 2014). Therefore, there is not one direct cause of distress and emotional disturbance as it is a combination of biological, developmental, and environmental factors (Beck & Weishaar, 2014).

**Theory of Change**

Individuals with emotional difficulties tend to have impaired cognitions that tilt objective reality in the direction of undervaluing one’s abilities and attributions (Corey, 2011). To change faulty cognitions and errors in thinking, CBT “fosters change in patients’ beliefs by treating beliefs as testable hypotheses to be examined through behavioural experiments” (Beck & Weishaar, 2014, p. 245). Changes in the client’s emotions and behaviour will occur by modifying inaccurate and dysfunctional thinking and replacing distorted cognitive processes with rational and realistic cognitions (Truscott, 2010). For change to take place, clients are expected to become aware of their cognitions and their reactions to upsetting situations, view their thoughts as a hypothesis not facts, replace accurate perceptions with inaccurate ones, and evaluate whether changes have occurred by collecting feedback and assessing change results (Truscott, 2010). Furthermore, cognitive change occurs by examining perceptions that shape an individual’s cognition, such as voluntary thoughts, automatic thoughts, underlying assumptions and by examining beliefs within cognitive schemas, called core beliefs (Beck & Weishaar, 2014).

**The Relationship Between Client and Therapist**

A positive and supporting relationship is necessary for effective therapy (Truscott, 2010). Successful counselling depends on a number of characteristics that the clients perceive from their therapists such as, empathy, warmth, non-judgemental acceptance, and establishing a rapport (Corey, 2011). The core conditions described by Rogers in client-centered therapy, which are congruence, unconditional positive regard, and empathic understanding are three functions that are necessary to develop a positive therapeutic relationship (Beck & Weishaar, 2014). An emotional bond between the client and the therapist will build the therapeutic relationship that produces a successful collaboration in which tasks and goals are discussed and followed through (Horvath & Greenberg, 1994). Collaboration between the client and therapist is also a key principle in CBT (Truscott, 2010).

**The Counselling Process**

**Client and Counsellor Roles**

As part of the collaboration process, the client and therapist each play key roles in all therapeutic sessions. The therapist’s role is to actively listen to the patient’s point of view and help the patient understand how their beliefs and attitudes affect their behaviour (Beck & Weishaar, 2014). The therapist encourages the client to share their thoughts to better help device appropriate techniques for the clients to use that focuses on cognitive change (Beck & Weishaar, 2014). As the therapist attempts to properly restructure the clients cognitive thought processes, they ask the client Socratic questions which help uncover underlying meaning behind patients’ perceptions (Chawathey & Ford, 2016). Finally, the therapist encourages and increases in the client’s participation and reinforces the rationale and goals they both have established in the initial sessions of therapy (Beck & Weishaar, 2014). The client’s role in therapy is to provide their thoughts and beliefs as they occur, as well as the emotions and behaviours that coincide with their thoughts (Beck & Weishaar, 2014). Since therapy is considered a collaborative process, the client is responsible to help set the agenda and goals in therapy sessions and complete homework or activities between sessions (Beck & Weishaar, 2014). The overall effectiveness and success of the counselling process is determined when the client addresses and changes their dysfunctional cognitions (Dobson, 2001).

**Addressing Cognitive Distortions**

Once the therapeutic relationship and roles of the therapist and client are established, the therapist examines the client’s systematic errors in thinking that lead to cognitive distortions (Corey, 2011). The therapist will address the client’s faulty assumptions and misconceptions to best learn how to treat the client (Corey, 2011). An example of a cognitive distortion is personalization. This is when a client believes that an external event relates to them in which there is no evidence to support this thought (Corey, 2011). A client may believe, for example, that their friends absence from a social gathering is due to their boring personality. The therapist will help modify these inaccurate and dysfunctional thoughts during treatment sessions.

**Time line**

Cognitive behavioural therapy is time limited and the length of treatment depends on the severity of the client’s problems (Beck & Weishaar, 2014). However, the average length of therapy is between 12 to 24 weekly sessions (Beck & Dozois, 2010). The initial sessions are often focused on building a relationship with the client, identifying the client’s problem(s), learning past history and diagnosis, setting up the timelines of therapy, educating the client on the processes of psychotherapy, and assigning homework (Beck & Dozois, 2010). Symptom relief is conducted through behavioural strategies and the therapist plays more of an active role then the client (Beck & Dozois, 2010). As therapy progresses, the emphasis shifts from behavioural techniques to cognitive techniques for symptom relief. (Beck & Weishaar, 2014). The client challenges their automatic thoughts that interfere with functioning, plays a move active role in therapy and continues to create and complete homework (Beck & Weishaar, 2014). Towards the end of therapy, the client should now be able to identify cognitive distortions and use cognitive techniques to solve problems (Beck & Weishaar, 2014). Clients can now apply the skills and techniques that they have learned in their everyday experiences. Booster sessions are followed by termination, usually by one or two sessions to follow up and assist clients in employing their new skills (Beck & Weishaar, 2014).

**Therapeutic Techniques and Procedures**

The change process in therapy involves addressing the client’s dysfunctional cognitions by using the appropriate therapeutic techniques ascribed in CBT. Techniques used are primarily focused on altering errors in information processing and adjusting core beliefs that permit dysfunctional cognitions (Beck & Weishaar, 2014). Truscott (2010) states that to treat cognitive distortions “the therapist draws from a range of empirically tested interventions to correct errors and biases in information processing and modifying thoughts that result in faulty conclusions and emotional distress” (p. 102). The therapist recognizes the client’s views and automatic thoughts, corrects them if they fail empirical and logical tests, and teaches them more adaptive and functional beliefs (Truscott, 2010). Furthermore, therapists teach their clients to monitor negative cognitions, recognize how they affect their behaviour and emotions, examine for evidence, substitute more realistic thoughts, and alter beliefs (Beck & Weishaar, 2014).

**Cognitive Techniques**

Cognitive restructuring techniques assist clients in identifying and test the validity of their cognitions (Beck & Dozois, 2010). Automatic thoughts can be tested in therapy by direct evidence and analysis. For example, a client may believe that they cannot carry on a conservation well, so behavioural experiments will allow client to think in a more objective, realistic way (Beck & Weishaar, 2014). Decentering is another useful cognitive technique where clients may believe that they are the focus of everyone’s attention (Beck & Weishaar, 2014). This cognitive error can be addressed by testing these beliefs by conducting behavioural experiments as well (Truscott, 2010). Thirdly, reattribution allows clients to test automatic thoughts by considering alternative causes to events, instead of realistic attributes to events that they have no control over (Truscott, 2010). Decatastrophizing helps clients prepare for feared consequences and develop problem solving strategies (Beck & Weishaar, 2014) Finally, redefining can help clients find opportunities and make changes to a problem they believe is beyond their control (Beck & Weishaar, 2014).

**Behavioural Techniques**

Behavioural techniques are used to modify automatic thoughts and assumptions by using behavioural experiments to challenge dysfunctional cognitions and modify beliefs (Beck & Weishaar, 2014). Behavioural techniques include assigning homework to apply cognitive principles that focus on self-monitoring and self-observation. Secondly, exposure therapy allows clients to examine specific thoughts or images that causes anxiety, examine distortions, and develop coping skills to challenge anxious thoughts in the future (Beck & Weishaar, 2014). In addition, role playing techniques are used to help clients practice the skills they have gained and apply them to real life situations (Beck & Weishaar, 2014). Finally, daily journaling and activity scheduling provides structure and encouragement as the client is involved in their change process (Beck & Weishaar, 2014). Writing down activities that give them pleasure and noticing mood fluctuations can provide evidence of contradictory thoughts (Beck & Weishaar, 2014).

**Indicators of Success and Measuring Client Change**

Cognitive behavioural therapy is one of the most researched and supported psychotherapies and has received an outburst of empirical support for successfully serving clients suffering from a variety of mental health conditions (Beck & Dozois, 2010). Research trials and experiments have continuously shown that cognitive behavioural therapy reduces the effects of anxiety, depression, chronic back, sleep disorders, eating disorders, post-traumatic stress disorders (PTSD) and many other mental health and neurological disorders (Beck & Dozois, 2010). Research trials and follow up with clients suggest that CBT can be just as effective as medications for the initial treatments of depression and yields lower relapse rates than antidepressant mediation (Beck & Dozois, 2010). In addition, the treatment efficacy using CBT in panic disorders shows the smallest-drop out rates and an increase in patient success compared to just appointing medical interventions (Firestone & Dozois, 2007). Cognitive behavioural interventions are the treatment choice for obsessive-compulsive disorder, PTSD, and social phobias (Firestone & Dozois, 2007). Client change can also be measured by clients effectively using techniques they have learned in therapy to reduce their cognitive distortions in everyday situations (Truscott, 2010).

**Working with Diverse Populations**

Understanding a client’s cultural background is a crucial factor in the therapeutic process. If therapists understand their client’s beliefs, values and attitudes, they can then help clients explore these values and gain an understanding into their conflicting and distortive cognitions (Corey, 2011). CBT does not intend to change the beliefs of diverse clients to suit the therapist’s values, instead it helps the individual examine their own beliefs and determine if they foster emotional well-being (Beck & Weishaar, 2014). Research on CBT has been conducted in many developed nations, but research needs to expand into developing countries to further grasp a better understanding of how to conduct CBT with diverse populations.

**Personal Reflection**

My personal theory of counselling started off relating to the humanist side of therapy, but after much research and exploration, I believe that my views mainly fall under the empiricist side of therapy, where CBT falls under. Empiricism argues that “Although life is seen as having many obstacles and struggles, there is always light at the end of the tunnel; problems can be solved through direct action” (Truscott, 2010, p. 11). As someone that as suffered and still experiences anxiety and depression, I believe that there is always hope and a solution to a problem if we take the appropriate action necessary. Since CBT is based on empiricist views, suitable strategies are applied to problems to achieve concrete, measurable outcomes (Truscott, 2010). Having taken part in CBT previously, I found that the therapist encouraged me to deactivate dysfunctional cognitions from my mind, modify their content and construct healthier and more adaptive thoughts (Beck & Weishaar, 2014). I found that the therapist encouraged me and approached my problems with a sense of optimism that made me believe that I could change. We collaboratively worked together and used techniques such as decatatrophizing. I was behind on the prerequisites upon entering this master’s program due to my concussions and I thought that if I asked for help from Candace or Erika that they would think I was stupid and would regret accepting me into the program. I avoided asking for help and got further behind and finally my therapist encouraged me to make what-if list to reduce my anxiety and encouraged me to call them and set up an appointment. Empiricism approaches therapeutic instruction with a “can do” spirit and encourages the client to modify their cognitions and actions to bring them closer to reality all while maintaining a sense of hope and optimism for the client (Truscott, 2010). I value the importance of the therapeutic alliance in CBT as well. I believe it is crucial for clients to feel heard and accepted by their therapist in order to treatment to successfully begin. I recognize that this alone does not produce change in the client, but feeling accepted and understood definitely helps to start the change process. I see the unbelievable benefits that CBT can offer and one day I hope that my father who suffers from alcoholism, depression and PTSD can reap the benefits that so many others have while entering in this type of therapy.

**Critical Analysis**

**Strengths**

Cognitive behavioural therapy has grown quickly as it has become the most heavily researched psychotherapy because of its strong empirical bases and demonstrated usefulness (Beck & Dozois, 2010). CBT has been successfully applied in the treatment of many disorders such as, depression, anxiety, drug abuse, alcoholism, anorexia and bulimia (Beck & Weishaar, 2014). Empirically validated treatments for these disorders have revolutionized the therapeutic practice. What makes CBT a success is that is draws different modalities from other therapies in an integrated approach (Corey, 2011). CBT shares theories and concepts from existential, gestalt and person-centered therapies. (Corey, 2011). CBT is also a short-term approach to therapy, which interests individuals as it can be seen as cost effective and efficient (Beck & Weishaar, 2014). Another major strength of CBT is that it is readily teachable. The strategies and techniques are ones that clients can use on themselves during therapy and once they have ended treatment (Beck & Weishaar, 2014). Finally, one key strength that CBT brings to therapy has “been bringing private experiences back into the realm of legitimate scientific inquiry” (Corey, 2011, p. 303). CBT values prediction and control, which allows client’s maladaptive cognitions to be treated as a testable hypothesis (Beck & Weishaar, 2014).

**Weaknesses**

One of the limitations and weaknesses of applying CBT to diverse cultures is that the therapist may not have an understanding of the client’s cultural background (Corey, 2011). Therapists need to exercise therapy with caution in order to challenge client’s cognitions, especially if it regarding their cultural beliefs. Some cultures have strict rules in regards to religion, marriage, and solving disputes, and for example, a wife questioning her husband’s motives and actions are forbidden in some Middle Eastern and Asian cultures (Corey, 2011).

Secondly, research and the effectiveness of CBT on depression is controversial at the moment. The National Research of Mental Health study of depression argued that CBT was not as effective in treating depression as other treatments such as interpersonal therapy or the use of antidepressants (Holmes, 2002). However, hundreds of empirical studies have demonstrated otherwise and have argued for the efficiency and success in the treatment of depression (Beck & Weishaar, 2014). There is a strong need for long term comparative studies to see if CBT is efficient in treating depression and see whether or not there is an increase in relapse in depression after CBT is conducted (Holmes, 2002).

**Future Considerations**

There is a need to expand CBT research further into developing nations as most research trials have only been conducted in developed nations (Beck & Weishaar, 2014). Research in the effectiveness in CBT is slightly bias as it mainly represents studies from cultures in developed countries, such as the United States and England (Corey, 2011). Further research is recommended into exploring the values and core beliefs of all cultures when conducting CBT. Finally, there is a need to continue researching the effectiveness of treating depression with CBT. Further research will clarify the mechanisms of change and which strategies produce the most stable and long-term cognitive change (Beck & Dozois, 2010). Future research will only increase the knowledge base of CBT and optimize therapy.

**Conclusion**

The emergence of CBT has provided many empirically based techniques and procedures that provide appropriate cognitive and behavioural changes to client. CBT has received a lot of attention and success for its beneficial techniques in helping those suffering from a variety of mental health disorders as this approach addresses correcting errors in thinking and modifies dysfunctional cognitions. CBT attempts to change client’s dysfunctional cognitions and behaviours into adaptive ones that allow for optimal, healthy functioning. Collaboration is seen as a crucial factor in the success of CBT and if clients use the techniques they have learned in therapy to monitor their behaviours and cognitions they will continue to form realistic and adaptive thoughts. There is no doubt that CBT will continue to grow in support and research as it has grown to be one of the most popular therapies used in the 21st century.

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