Module:
Psychological Foundations of Mental Health

Week 5
Psychological therapies: from behaviour modification to behaviour therapy

Topic 3
Cognitive therapy in principle and in practice – Part 1 of 3

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Lecture transcript

Slide 3
Cognitive therapy and CBT for depression describe a range of tools and techniques that are applied within the framework of the cognitive model to address its maladaptive contents, whether this is the negative automatic thoughts, the cognitive distortions that underpin them, our behavioural responses, such as avoidance or safety behaviours, or our schema.

Although a common set of tools is available, how they are applied is or should be highly individualised to the person's specific situation and presentation. The aim is always to achieve a positive therapeutic outcome. This is commonly measured in terms of symptom reduction, using standard measures, such as the BDI for depression, or, more broadly defined, distress.

However, the real aim is to improve real life function in overall health and quality of life, in personal relationships, performance at college or at work, and so on. A further goal of cognitive therapy and, indeed, all psychotherapies is not just to treat the symptoms. Rather, it is to provide the individual with new insights, understanding, and skills that allow them to deal with both their current situation and future ones.

The goal of reducing risk of future episodes of depression is one of the biggest opportunities offered by cognitive therapy over other approaches, such as medication. However, as we will see next week, it is also one of the biggest challenges and one that is driving the development of new therapies. For now though, in this topic, we will continue to consider traditional cognitive therapy for depression.

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Before looking at some of the tools and techniques of cognitive therapy, let's consider some key features that govern how therapy is delivered. The first is that the cognitive model is made explicit from the outset. It is not just there to guide the therapist.

The cognitive model, while simple and intuitive, is not one that many people naturally use when considering their own situation. More commonly, people seeking help tend to have a simpler model, like the one on the left. We often assume that how we feel is governed by specific events or the general situation of our lives, past and present.

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Clients may believe that there is nothing that can be done to control events or to change their situation. This may be partly correct. But with a simple causal model, it can lead to distressing feelings of hopelessness and powerlessness of the client feeling trapped.

At the beginning of treatment, the basic cognitive model is explained. This starts simply and builds over the course of therapy, just as we did in the last topic. The purpose of explaining the cognitive model is to emphasise the interrelationship between our thoughts, our feelings, and behaviours, and how problems can be maintained by vicious cycles.

It provides the essential rationale for adjusting how we think and how we behave to improve how we feel, even if we cannot change our situation or control unpredictable events. This can offer an element of control back to patients.

Understanding this basic idea is both central to the rationale of cognitive therapy and CBT, but also essential. Evidence suggests that people who clearly understand the model and believe that it can be applied to their situation tend to engage more with their therapy process and have better outcomes.

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Understanding and appreciating the model is usually done early, using real examples that the client has described during an initial assessment. This may involve using a blank hot cross bun model, like we see here, and guiding the client to fill in the parts.

For example, a client may have reported that he feels tired when he wakes up in the morning, with unpleasant tension in his stomach. So he is encouraged to write that in the space of physical feeling. He is then asked, how do you feel when you wake up like that? The client may say that he feels anxious and worried.

The therapist then asks, what sort of thoughts are going through your head? The client may say that he's worried about his work. And when prompted further, he said that he will not get his work done properly that day, because he's feeling so tired. Further prompting reveals that he's worried that his boss will think that he's bad at his job and will want to get rid of him.

He would then be asked, what do you do on mornings like this, when you wake feeling tired and anxious? The client may say that he finds it very hard to get out of bed, that he can't get back to sleep, but doesn't want to get up.

Finally, he may be asked, how does this affect what is going on around you, such as other people in the home? The client may say that his wife shouts at him and tells him he'll be late for work, which makes him even more anxious. Sometimes, he says that he is ill and calls into work to say that he's sick. Other times, he may get to work late.

Although just one example, it's a real one and relevant to the client. Using it early in therapy can help him see the chain of thoughts, feelings, behaviour, and the consequences that flow from his experience of waking in the morning feeling tired. In particular, it links his anxiety and concerns about work with his tendency towards avoidance, staying in bed, or calling in sick. This early process is sometimes called socialising the client to the cognitive model.

Slide 6

Let's continue looking at some other fundamental principles that guide the therapy process. Once the general cognitive model has been explained and illustrated with specific examples, a more general, individualised model is typically developed, called a conceptualisation or formulation. This draws together the client's specific circumstances, concerns, and ways of dealing with them that may serve to maintain their distress.

The process of therapy is fundamentally collaborative. The client and the therapist work together to

understand the nature of the problem and its interrelationships, and jointly find ways to address the unhelpful thoughts and behaviour. Building a so-called collaborative alliance is an important predictor of therapy outcome.

Cognitive therapy or CBT is not an open-ended treatment. Typically, clients and therapists would agree in advance how many sessions there will be. Most involve meeting weekly or fortnightly for 12 to 20 sessions in total. The general plan for the sessions is outlined from the outset.

Each therapy session is typically structured and addresses one or two topics. To maintain the focus, the purpose of the session is typically set out in advance with a clear agenda, with a summary at the end, and with an outline for the next session.

Therapy addresses things that are happening to the client at this time and do not depend on understanding how a problem might have arisen in the first place. It is a practical approach, helping the client to develop a range of new thinking and behavioural skills. The exception to this is work around understanding and modifying the schema, the core beliefs that shape the client's thinking and behaviour.

The fundamental approach of cognitive therapy is inherently a scientific one. The client does not have to understand the scientific method in detail, but the therapist will make a number of points clear early on. First, that the individual conceptualisation is a best guess, based on the available evidence. In other words, it's a hypothesis. If it doesn't fit and is not useful in guiding therapy, the model can be adjusted.

Second, through the course of therapy, the therapist guides the client to look for evidence to determine whether their model is an accurate one or not. Third, the client is encouraged to actively test the accuracy of their own perceptions and expectations. This is an important part of the process of identifying and challenging any cognitive distortions that are present.

In supporting this scientific questioning approach, therapists often make use of what is called Socratic dialogue or Socratic questioning. This is a method of instruction attributed to the philosopher Socrates, who did not teach by telling his students the solutions or what to do, but posed questions to guide them to find solutions for themselves.

In therapy, a client may describe a difficult situation that has happened to them or concerns about something that may happen in the future. The therapist might prompt with questions such as, have you been in a similar situation before? What did you do and what happened? Have you learned anything useful from the recent instance? Or what would you recommend a friend to do in a similar situation?

Clients will be asked to keep records and diaries and provide numerical ratings of their thoughts, feelings, and behaviours. This underpins the idea that therapy is systematic and scientific, gathering evidence and testing hypotheses. The new information can also provide evidence of change as the client tries new strategies, useful both for the therapist and the client.

Finally, treatment involves homework for the client to do between sessions. This might include self-monitoring and record keeping, exercises around any distorted thinking, or changing aspects of their behaviour. This homework is a crucial part of the therapeutic process. Without it or without the client actively engaging with it, outcomes tend to be less good.

Slide 7

We will now look at a few of the techniques and tools that underpin cognitive therapy and CBT, whether for depression, anxiety, eating disorders, or whatever. This is by no means a complete description. The aim here is just that you can see how the techniques used in therapy derive directly from the cognitive model and are designed to address factors that lead to maintain the problem in

question.

Slide 8
Most of us are guilty of believing the accuracy of our own perceptions, memories, and thoughts. The existence of systematic biases and distortions in our thinking is an important fact to explain early in cognitive therapy. Being able to recognise when we are making thinking errors allows us to correct them. Clients are often given a list of descriptions and examples of cognitive distortions, like the one you will find in this week's KEATS page.

They may also be given quizzes to help them learn to identify the different types of distortion. Finally, during the course of therapy sessions, the therapist may prompt the client to think about a statement that they had just made and whether it reflects a cognitive distortion and, if so, which one.

Here's an example.

Slide 9
Before we go through the conversation that follows, what cognitive distortions can you detect here? Have a go at answering before carrying on.

Slide 11
Let's follow the conversation and check what cognitive distortions the client was able to identify, following the therapist's prompts.

Slide 12
Early in the process of therapy, clients are given homework to help them think about their thinking. Our thoughts are often like a background narrative, and we tend to spend more time focusing on how we feel than on the thoughts themselves. The situation, the thoughts, and the feelings tend to get rolled together, rather than considered as separate if interrelated components.

Separating out the negative thoughts and connecting them to how we feel is the first skill to be learned. One of the basic tools for this process is the thought record. The client is asked to write down examples of times when they felt upset, not every instance, but enough to provide evidence for discussion. The simplest format is illustrated here, with three columns.

The first column is a brief but specific description of the situation in which the negative mood was experienced, either at the time or leading up to it. The client might record aspects of the situations, such as who else was involved, what was happening, when it was, and where. This is like the antecedents in the ABC charts that we looked at earlier.

The second column provides space to record the mood or emotion that was experienced. This will include both a description of the mood, but also a rating of its intensity, typically on a nought to 100 scale.

The third column is really the important one and the one that many clients find most challenging to begin with. This is to identify some of the thoughts that happened just before or as the negative feelings started. We see a couple of examples here. We will pause a moment while you read them.

Slide 13
You will see how the thoughts make sense in connecting the situation to the feeling. With practice, the client also learns this important relationship. Such records may be kept over the course of therapy.

Often, a number of recurring themes emerge in terms of the thoughts that the client has across different situations. These are sometimes called hot thoughts and ones that are generalised and most directly related to the experience of negative emotion.

A couple of possible hot thoughts are highlighted here. Clients are helped to identify such hot thoughts. Recognising them as they happen can be easier than monitoring the full range of thoughts that run through our heads as we go through our day. If we recognise the hot thoughts at the time, we are better able to deal with them quickly and prevent the vicious cycle developing.

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