The Specialist Academy

Cognitive Behavioural Therapy (CBT)

Course Manual

Course Contents

The Specialist Academy

Module 7:

The Cognitive-Behavioural Framework: Implementing a CBT session

Objectives:

This module explores the implementation of a CBT session in practice through the lens of the Cognitive Behavioural Framework. This section focuses on the Middle state and end stage of CBT, including the collaborative therapeutic relationship, the cognitive model process and processes by which the client is helped to work on problem(s) both in and out of session. By the end of this module, the learner will have developed an understanding of these components of a CBT session in line with current recommendations.

Middle stage of CBT

As a developmental process, therapy is determined in part by the client and in part by the therapist and as such is a changing process across the beginning, middle and end stages with some overlap existing across these sections. The cognitive conceptualisation aids the focus of the therapeutic intervention across all three stages and provides a stable, salient standpoint from which to address a wide range of issues which may arise over the therapeutic journey as a whole.

The cognitive conceptualisation and the therapists own goals have been held in tandem as equally important to the outcome for the client (Curwen et al., 2000) and overall, the therapists goals can be grouped into three categories which are then used to frame the cognitive conceptualisation in an individualistic, person-centred manner:

1. Collaborative therapeutic relationship
2. The cognitive model process
3. Helping the client to work through issues both in and out of the structured therapy environment

These areas structure the therapy sessions and the therapist's goals guide the content, where the categories remain static and the goals can organically shift in focus. The role each of these target areas plays in the middle stage of the therapy relationship will now be discussed.

Collaborative therapeutic relationship

Continue to maintain collaborative relationship between therapist and client

Also referred to as the therapeutic alliance (Curwen et al., 2007), the manner in which the therapist and the client work in together to resolve issues is of vital importance to the clients therapeutic outcome.

Provide positive, encouraging feedback to the client

With roots in systems theory (Bertalanffy's, 1952), feedback can be defined as information given to the client which supports them by communicating that they are doing or saying the right thing. In CBT feedback is given to the client in regular intervals and in a number of different ways, for example, feedback should be provided to the client following every positive movement toward the therapeutic goals. By doing this, it is thought that the client progresses through therapy faster and encourages a positive relationship with the therapist and the process of CBT itself.

Cognitive model process

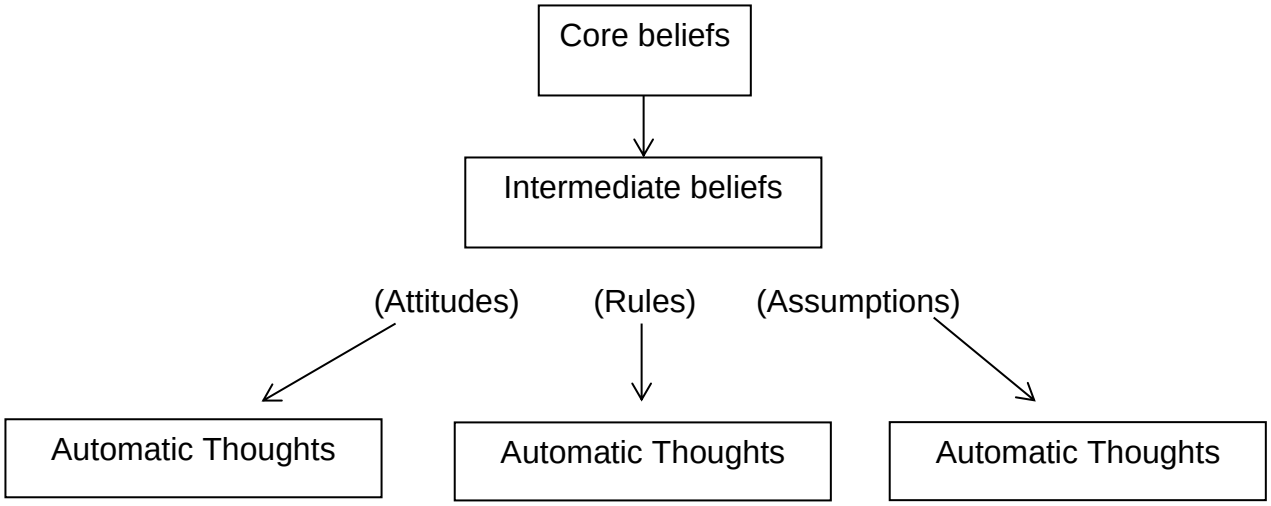
Change the focus of the therapy from negative automatic thoughts, to positive

The purpose of CBT, particularly brief cognitive therapy, is to help the client reach the stage where they can confidently reach short and long term goals independent of the therapist. However, in situations where the client is diagnosed with a personality disorder, brief therapy would be inappropriate and largely unsuccessful (Freeman & Jackson, 1998). Dependent upon the client, a therapeutic focus on negative automatic thought is all that is required to reach the end goal of CBT, however, other groups of clients may need to work on core beliefs prior to moving the focus on to automatic thought, as in this client group, these drive the negative automatic thought processes.

The cognitive model states that when processing new information, we distort (Curwen et al, 2007) this based upon pre-existing conceptual frameworks individual to each person, this process helps us make sense of the world around us and key life events. Automatic thoughts arise from our underlying beliefs, consisting of intermediate belief and core beliefs. These are ‘overgeneralised, inflexible,

imperative and resistant to change' (Beck et al., 1990: 29) and may be positive or negative. Intermediate beliefs lie between core beliefs and automatic thought and are divided into three types: attitudes, rules and assumptions as illustrated below.

The structure of beliefs: schema representation



The first thing that a therapist must do prior to embarking with a CBT session is identify these underlying beliefs. In order to do this, the therapist may utilize a number of tools and resources available to them, such as the downward arrow technique also referred to as the vertical arrow technique (Burns, 1989); Sentence completion (Padesky, 1994) or belief questionnaires (Weisman & Beck, 1978).

Once underlying beliefs have been identified, the therapist must work in collaboration with the client to alter these beliefs following an ethical protocol as discussed in Module 9. Prior to moving towards modifying these core beliefs, the therapist must feel confident that the client can now identify and question their negative thought processes yet is failing to improve, finally, the client must be able to recognise a number of their underlying (core and intermediate) beliefs are automatic thoughts.

Methods which the therapist may utilize in order to modify these beliefs are: Socratic dialogue (Beck et al., 1976); Scaling beliefs (Beck et al., 1990) otherwise referred to as the continuum method (Padesky, 1994); Fixed role therapy; Role play (Fagan & Shepard, 1970) and behavioural methods (Emmelkamp et al., 1978) to name a few. Tools which the CBT practitioner may use in order to assess a client's underlying

beliefs and automatic thought are the belief change chart (BCC) and the cognitive conceptualisation chart (CCC).

Educate the client about self-acceptance

The role in which poor self-acceptance playing in the maintenance of negative underlying beliefs should not be undermined. Although previously discussed methods of assessment and intervention can be useful for addressing issues of poor self-acceptance in the client, other more specific techniques can be of direct help for this population.

Therapist should convey to the client in this respect that global ratings e.g. 'I am worthless' are not applicable to the complex nature of humans and as such, the use of such ratings is illogical, unrealistic and unhelpful. A form of thinking error, over-use of global ratings can also draw parallels with stigmatisation (Goffman, 1963) against minority groups such as ethnic minorities and people with a disability. It has been suggested (Korzybski, 1933) that the over-use of global ratings can result in distorted thinking, where the self aside from traits, aspects and behaviour is assessed in such terms.

In order to assist the client in moving away from global ratings and towards acceptance of the self as a fallible being, the therapist may implement the 'Big I, Little I' technique which emerged from the work of Lazarus (1977) on the egoless self, an extension of Freudian psychoanalysis. Further techniques which may be used are visual methods and interventions, homeworks such as a bibilogrpahy of self-help literature (Dryden & Gordon, 1990), listening to self-help recordings (Ellis, 1977), imagery (Maultby & Ellis, 1974). Making recordings of the therapy sessions van be of benefit to both the therapist and the client, the client can be given the recording and instructed to listen to it outside of the therapy session to reaffirm lessons learnt in-session and aid understanding of concepts discussed.

Help the client to work on problems both in and out of the therapy session

Pass responsibility for therapeutic work over to the client

From the opening stages of the therapeutic relationship, the CBT practitioner works with the client to equip them with the skills to become their own therapist as

previously discussed. Using techniques discussed in earlier stages of this module, such as Socratic dialogue, the therapist helps the client to discover healthy coping mechanisms for themselves, alongside confidently identifying cognitive distortions which may arise in certain situations. The overarching goal of the middle stage of CBT is to encourage the client to take a more active role in the sessions by assigning themselves homework and taking a note of the key points addressed in the session. Coupled with the use of other therapeutic tolls as discussed in this, and previous modules, the client learns to take on responsibility for change.

Encourage the client to become their own therapist

In CBT, it is the aim that the process by which the client becomes their own therapist is a natural, unforced process which begins in the early stages of therapy and develops parallel to the client taking responsibility for therapeutic change. By assigning homework to the client, this not only aids in the development of coping strategies and reflection on own thought processes, but encourages the client to take action when issues arise (Curwen et al., 2007) as opposed to engaging in negative cycles of behaviour as prior to intervention. Approaches such as that developed by Wasik (1984), a problem solving worksheet based upon seven steps encompassing corresponding questions can be useful for promoting problem solving behaviour.

Encourage client to continue with tasks between sessions

Homework promotes the development of problem-solving techniques outside of the session, without the therapist present. This is a key feature of CBT across beginning, middle and end stages, research has shown that clients who actively engage in this show greater positive outcome (Niemeyer & Feixas, 1990). Homework has been discussed in greater detail in other modules.

Prepare clients for setbacks and ending therapy – lapse and relapse reduction

From the first session, the therapist prepares the client for the termination of therapy, however, in the middle stage of therapy, the CBT practitioner places emphasis on handling setbacks and reducing the risk of relapse following the end of therapy. If setbacks arise across therapy, this is viewed as an opportunity to practice coping strategies and techniques in the therapy session before moving to the external

environment; this is sometimes referred to as relapse reduction or relapse prevention.

Multiple Choice Questions

1. *Overlap exists between the beginning, middle and end stages of CBT*
   a) *True*
   b) *False*

2. *The technique which focus' the aim of the intervention across all stages is termed:*
   a) *Cognitive conceptualisation*
   b) *The cognitive model*
   c) *Case formulation*

3. *Therapist goals can be grouped into:*
   a) *Three categories*
   b) *Five categories*
   c) *Eight categories*

4. *The manner in which the therapist and the client work in together to resolve issues is termed:*
   a) *Collaborative action*
   b) *Therapeutic alliance*
   c) *Rapport*

5. *Feedback is*
   a) *information given to the client which supports them by communicating that they are doing or saying the right thing*
   b) *information given to the client which supports them by communicating that they are doing or saying the wrong thing*
   c) *information given to the client upon termination of therapy*

6. *What is the purpose of CBT?*
    a) *To help the client reach the stage where they can confidently reach short and long term goals independent of the therapist*
    b) *To enable the client to access help when necessary*
    c) *To allow the client to become dependent on an outside agency*

7. *Which model state that when processing new information, we distort our thinking*
    a) *The cognitive model*
    b) *Case conceptualisation*
    c) *Freudian theory*

8. *Intermediate beliefs can be divided into three areas:*
    a) *attitudes, rules and assumptions*
    b) *Antecedent, behaviours and consequences*
    c) *Beginning, middle and end stages*

Bibliography

Beck, A. T., & Lester, D. Components of suicidal intent in completed and attempted suicides. The Journal of Psychology, 1976, 91, 35-38.

Beck, A. T., & Steer, R. A. (1990). *BAI, Beck anxiety inventory*. Psychological Corporation.

Bertalanffy, L. V. (1952). Problems of life. *London: Watts*.

Curwen, B., Palmer, S. & Ruddell, P. (2000) *Brief Cognitive Behaviour Therapy* London: SAGE.

Curwen, B., Palmer, S. & Ruddell, P. (2007) *Brief Cognitive Behaviour Therapy* London: SAGE.

Dryden, W., & Gordon, J. (1990). *What is Rational-Emotive Therapy: A Personal and Practical Guide*. Gale Centre Publications for the Gale Centre.

Ellis, A., & Knans, W. Overcoming procrastination. New York: Institute for Rational Living, 1977.

Emmelkamp, P. M., Kuipers, A. C., & Eggeraat, J. B. (1978). Cognitive modification versus prolonged exposure in vivo: A comparison with agoraphobics as subjects. *Behaviour Research and Therapy*, *16*(1), 33-41.

Fagan, J., & Shepherd, I. L. (1970). Gestalt therapy now: Theory, techniques, applications.

Freeman, A., **& Jackson**, J. (**1998**). **Cognitive behavioural treatment** of personality disorders. In N. Tarrier, A. Wells, & G. Haddock (Eds.), Treating complex cases: The **cognitive behavioural therapy** approach (pp. 319–339). West Sussex

Goffman, E. (1963). Behavior in public place. *Glencoe: the free press, New York*.

Korzybski, A. (1933). A non-Aristotelian system and its necessity for rigour in mathematics and physics. *Science and Sanity*, *1933*, 747-761.

Lazarus, R. S., & Cohen, J. B. (1977). Environmental stress. In *Human behavior and environment* (pp. 89-127). Springer US.

Maultsby Jr, M. C., & Ellis, A. (1974). Technique for using rational-emotive imagery. *New York: Institute for Rational-Emotive Therapy*.

Niemeyer, R. A., & Feixas, G. (1990). The role of homework and skill acquisition in the outcome of group cognitive therapy for depression. Behaviour Therapy, 21, 281–292

Padesky, C. A. (1994). Schema change processes in cognitive therapy.*Clinical Psychology & Psychotherapy*, *1*(5), 267-278.

Wasik, B. (1984). Teaching parents effective problem solving: A handbook for professionals. *Unpublished manuscript. Chapel Hill: University of North Carolina*.

Weissman, A. N., & Beck, A. T. (1978). Development and validation of the Dysfunctional Attitude Scale: A preliminary investigation.

