The Specialist Academy

# Cognitive Behavioural Therapy (CBT)

# Course Manual

# Course Contents



 

The Specialist Academy

# Module 5:

# Characteristics of CBT

 

## Objectives

This module will explore the characteristics of a CBT session in practice, having previously examined the theoretical basis and structure of CBT. Following completion of this module, the learner will have an understanding of the following methods involved in CBT: Therapeutic style; Formulation of problem; Collaborative relationship; Structure to sessions and to therapy; Goal-directed therapy; Examinations and questions, including unhelpful thinking; Use of a range of aids and techniques; Teaching the client to become their own therapist; Homework setting; Time-limited CBT sessions and Audio-recorded sessions.

## Therapeutic style

As a starting point to set the scene for describing the characteristics of a typical CBT session, the therapeutic style of the CBT practitioner is central. It is important at this stage to recognise that, when addressing the therapeutic style enacted in the field of CBT, this is fundamentally different to that of other forms of counselling (Curwen et al., 2000). The key underlying difference is that of the pre-existing skills and theoretical knowledge-base of the practitioner upon entering into a therapeutic relationship with a client. This places the practitioner in an initial position of power in the opening stages of the therapeutic journey, allowing them to actively manage the direction in which each session goes. By doing this in an empathetic manner, the practitioner can draw information from the client, to include information on their cognitive processes, (Curwen et al., 2000) which may be of benefit to the success of the treatment plan.

## Formulation of the problem

Once the initial therapeutic relationship has been established by the implementation of the CBT practitioner therapeutic style, this enables the practitioner to begin to collect information both about the client in general and also about the underlying issues which led them to undertake CBT. The ways in which this information is gathered are two pronged: firstly, verbal information is taken from conversations between the client and the practitioner; secondly, the therapist extracts information based upon their own observations of the clients behaviour, including a full structured assessment which will be discussed further in subsequent modules.

 

Based upon this information, the CBT practitioner produces what is termed a cognitive formulation or conceptualisation of the central issue with which the client is presenting. Rather than being a static formulation, the cognitive formulation is fluid, changing with the introduction of new information across CBT sessions, this is of particular relevance to the clients thinking processes such as that associated with problematic behaviours and emotions, including precipitating and maintaining factors and the client's interpretation of events as will be further discussed in modules 10-17.

**Collaborative relationship**

The processes by which the cognitive formulation is developed and subsequently structured is not closed to the client, rather, this is an open process which the client is involved in with full transparency (Curwen et al., 2000). When discussing influencing factors on the cognitive formulation with the client, the CBT practitioner should take care to describe these in either verbal or written language (Lazarus, 1971; Macaskill & Macaskill, 1991) which is easily understood and based upon a theoretical evidence base. By involving the client in the therapeutic process, the practitioner can enable the development of the clients understanding and recognition of concepts such as automatic thoughts and false beliefs. This understanding is of importance when implementing therapeutic methods such as homework, which will be discussed later in this module. Through these processes, the CBT practitioner actively encourages the client to engage with and take responsibility for, the therapeutic sessions.

In order to further the collaborative relationship between client and practitioner, an agenda is often drawn up at the beginning of each session which enhances the therapeutic relationship, accelerating the development of rapport and trust between the two parties. However, one must consider that this stage of the development of the client/practitioner relationship may be prolonged dependent upon the severity of the psychological issues which the client presents with (Beck et al., 1990).

**Structure to sessions and to therapy**

The structure of therapy sessions are based upon an agenda drawn up in collaboration with the client at the beginning of each session, as discussed

 

previously. This is heavily influenced by the problems and/or diagnosis the client presents with, informed by diagnostic tools such as DSM-V AND ICD-10. Aside from the first session, the format of each subsequent session is the same; this is common across all certified CBT practitioners as follows:

1. Check the clients mood
2. Brief review of week
3. Set agenda for current session
4. Feedback, and link to, previous session
5. Review homework
6. Discuss agenda items
7. Set homework
8. Seek feedback at end of session

The benefits of following this protocol are multifaceted, firstly, this aids in the effective management of time during sessions, it ensures that areas of importance to both the client and the CBT practitioner are addressed and it enhances the collaborative relationship between client and practitioner. In addition to this, by developing an agenda, the practitioner is equipped with a tool which is helpful for the monitoring of the clients progress across the therapy sessions and equips the client with a structure to use outside of the session, to be continued when the CBT sessions end.

**Goal-directed therapy**

In the role of therapist, the CBT practitioner guides the client to discuss their thoughts, feelings and actions in behavioural terminology. By discussing issues faced in such concrete terms, the client and practitioner can develop goals which the client works towards both in and out of the therapy session. The therapist must be clear with the client regarding the tasks which are necessary in order to meet the goals, maintaining targets which are person-centred, manageable, achievable and measurable (Lazarus & Fay, 1990).

**Examines and questions unhelpful thinking**

In terms of the characteristics of CBT, one must refer to the key theoretical components of the Cognitive Behaviour Model of Emotional Distress (Dobson &

 

Dobson, 2009) discussed in earlier modules. Working at an inferential level at the beginning stage, CBT does not directly address unhelpful thinking, rather, takes a socratic questioning approach (Curwen et al, 2000) which encourages the client to unpick the supporting evidence for their core beliefs and automatic thoughts (Beck et al., 1979), however, Ruddell (1997) highlights the importance of identifying possible cultural differences before implementing this approach.

Palmer and Dryden (1995) and Palmer and Strickland (1996) devised a list of questions regarding automatic thoughts and core beliefs to guide CBT practitioners in the development and maintenance of goal-directed therapy, an extract of which is illustrated below:

**Questions to examine unhelpful thinking**

- *Is it logical?*
- *Would a scientist agree with your logic?*
- *Where is the evidence for your belief?*
- *Where is the belief written?*
- *Is your belief realistic?*
- *Would your friends and colleagues agree with your idea?*
- *Does everybody share your attitude? If not, why not?*
- *Are you expecting yourself or others to be perfect as opposed to fallible human beings?*
- *What makes the situation so terrible, awful or horrible?*
- *Are you making a mountain out of a molehill?*
- *Will it seem this bad in one, three, six or twelve months' time?*
- *Will it be important in two years' time?*
- *Are you exaggerating the importance of this problem?*
- *Are you fortune telling with little evidence that the worst case scenario will actually happen?*
- *If you 'can't stand it' or 'can't bear it' what will really happen?*

**Uses range of aids and techniques**

The conceptualisation, as previously discussed, is the basis upon which the therapy is structured. Due to this, it is therefore possible for the CBT practitioner to

 

implement a wide and varied range of aids and techniques to reach the best possible outcome for individual and group clients. Specifically, these techniques have the collective aim of aiding the client in overcoming unhelpful thinking (Curwen et al., 2000). It must be emphasised that aids and techniques used in CBT are integral to the universal therapeutic framework and are not implemented independently of this. One such technique used primarily with clients diagnosed with panic disorder, is termed ‘voluntary hyperventilation’ (Clark, 1986). In terms of aids used in CBT, these can range from questionnaires (Ruddell, 1997) or forms (Curwen et al., 2000), the most common of which, the Beck Depression Inventory (BDI), is often utilised with clients with depressive disorders (Beck et al., 1961; Beck and Steer, 1987).

**Teaches client to become own therapist**

All of the afore mentioned techniques and methods which structure and guide individualised CBT come together to equip the client with the skills to effectively become their own therapist by helping them develop problem solving skills to implement outside of therapy and after therapy has terminated. Central to the success of this is that the client is an active participant in therapy, coupled with the severity of the issues a client may face.

**Homework setting**

Active participation is further encouraged through homework setting. In a CBT setting, homework is of vital importance due to the time-limited nature of CBT sessions which tend to place an emphasis on the problem rather than the solution. Homework also aids in the maintenance of continuity between therapist and client across sessions, however, care must be taken to ensure that the labelling of tasks as ‘homework’ will not induce negative thinking cycles at an individual level. Homework varies across practitioners, clients and settings, but often involves filling in behaviour forms or diaries to self-monitor thought processes outside of therapy, such as an automatic thought form (Curwen et al., 2000).

 

## Audio-recorded sessions

Although not an official part of a CBT session, many practitioners opt to audio-record their sessions as this has been found to be a useful supervisory tool, as long as full consent has been obtained from both the therapist and client. Referring back to homework, the practitioner may instruct the client to self-record and listen back to sessions at home. Curwen et al (2000) state that audio-recording also supports the development of the therapeutic, collaborative relationship between therapist and client and also aids in the development of the client as their own therapist.

 

**Multiple Choice Questions**

1. *The therapeutic style of CBT is similar to that of other forms of counselling*
   a) *True*
   b) *False*

2. *The CBT practitioner draws information from the client by:*
   a) *Empathetically managing the direction of the session*
   b) *Allowing the client to direct the session*
   c) *Focusing on negative thought processes*

3. *Information is gathered using:*
   a) *Multiple approaches*
   b) *A single approach*
   c) *A dual approach*

4. *A conceptualisation of the client's main symptomatic presentation is termed:*
   a) *A cognitive formulation*
   b) *A functional assessment*
   c) *Systematic analysis of behaviour*

5. *The format each session typically follows a common structure made up of*
   a) *10 stages*
   b) *20 stages*
   c) *8 stages*

6. *The Cognitive Behaviour Model of Emotional Distress was developed by:*
   a) *Dobson & Dobson*
   b) *Skinner*
   c) *Beck*

 

7. *CBT examines unhelpful thinking using:*
    a) *A socratic questioning approach*
    b) *Instrumental questioning*
    c) *A direct approach*

8. *Which of the following is integral to the success of CBT?*
    a) *Homework*
    b) *Active participation*
    c) *Both of the above*

 

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