Cognitive Behavioural Therapy

Chris Worfolk

Introduction

Welcome to the *Cognitive Behavioural Therapy (CBT)* course handbook. This serves as an additional set of notes to accompany the lessons but I would encourage you to maintain your own notes as well.

Foundations

CBT is an evidence-based talking therapy that uses the cognitive model to help us understand ourselves and behavioural techniques to change what we do and how we feel.

Features of CBT:

- Uses targets and goals to find solutions to problems
- Focused on the present rather than examining where problems come from
- Clients participate in the progress and complete homework: progress happens outside of the therapy sessions
- Therapists may make suggestions and be more directive than in other talking therapies
- Time-limited rather than going on indefinitely

While a course of CBT may not conform to all of these rules, these are typical of what using CBT may look like.

Comparison with other therapies

CBT shares a focus on the present with **person-centred therapy**. However, in person-centred, the relationship between therapist and client (the therapeutic alliance) is all that is required whereas CBT uses additional technology. Note that I say "additional": a strong relationship with clients is still important! Person-centred is also non-directive and most of the work takes place inside the therapy room. It treats the client as the expert in themselves, whereas in CBT the therapist and client co-construct the therapy.

Psychodynamic, the wider field of Freud's psychoanalysis, diverges father from this in that it focuses on how childhood experiences, suppressed desires and the unconscious affect our behaviour.

Another interesting comparison is that of **mindfulness**. Mindfulness focuses on how we interact without thoughts, whereas CBT deals with the thoughts themselves. But, as well shall learn, mindfulness and CBT have since been integrated by several modalities.

Strengths and limitations

Strength of CBT:

- Strong evidence base
- Easy to measure results
- Works well for people who like structure
- Particularly effective for specific problems like panic and phobias
- Produces results quickly

Limitations:

- Less emphasis on the personal relationship
- May not always deal with underlying causes
- No more effective than person-centred over the long term

History and development

Behaviour therapy sprang up as a response to the ideas of Sigmund Freud that psychologists like B. F. Skinner thought were overly complicated. Behaviourists advocated that people were more like machines with inputs and outputs that could be manipulated.

While this was not entirely without merit, Aaron Beck argued that this under-appreciated the complexity of the human brain and developed cognitive therapy to work on the cognitive model he had developed.

Beck later combined the two to form cognitive behavioural therapy. This new therapy used the cognitive model to understand what was happening and then drew in behavioural elements to help us make changes.

Biopsychology

CBT starts from the premise that thoughts, feelings and behaviours all affect

each other. Negative thoughts can make us feel bad and avoid situations. Feelings can make us assume the worst. Behaviours can reinforce thoughts.

But the reverse is also true. By changing one thing we can modify the others. By challenging a thought we can make ourselves feel better. By doing something different we can change our thoughts.

Conceptualising problems

Adopting this model, we can conceptualise problems as consisting of these three areas. For example:

Disorder	Thoughts	Feelings	Behaviours
Depression	"I am worthless"	Sadness, apathy, low energy	Reducing social contact and staying in bed
Panic	"I am going to die"	Fear, rapid heart rate, sweating	Avoidance

OCD | "My hands are contaminated" | Anxiety, disgust | Repeated washing |

The brain

We often think of the brain as one system: it is like the central processor running the body. From a wide view, this seems accurate. However, as we zoom in we see the situation is more complex.

The brain has evolved over millions of years and has a series of layers to it: the hindbrain, the midbrain and the forebrain. These parts of the brain are often in agreement with each other but this is not always the case.

Take the example of a phobia of bananas. Many people who struggle with this are fully aware that bananas are not dangerous. But another part of their brain disagrees and triggers a strong emotional reaction when it comes near a banana.

Why is this relevant to therapy?

Different parts of the brain will respond to different interventions. For example, a cognitive intervention may help a client accept that the banana is not inherently dangerous while a behavioural intervention may be required to convince the hindbrain that it does not need to panic.

Clients may be confused by this discrepancy: they may feel that because they have successfully challenged a thought like "the banana is dangerous" the feelings should go away. But allowing the emotional system to catch up may take more time and effort.

Brain, chemicals and mood

Emotions are not something that happens in the theoretical landscape of the mind: they are real things that occur within the body.

The brain has two ways of communicating with the rest of the body. It can send neurotransmitters along the nervous system and it can trigger the release of hormones into the endocrine system which are carried around the body in our blood.

This is another way in which thoughts, feelings and behaviours are connected. When a thought causes you stress, there is a physical release of chemicals in the body that will change how you feel. Those feelings can be detected body and sent back to the brain. And all of this affects how we choose to behave.

Memory

Memory can be divided into working memory (previously known as short term memory) and long term memory.

Working memory can only hold a very limited amount of information for a short amount of time. After that, if it is not stored in long term memory, it is forgotten. We can keep the information in working memory using rehearsal.

The process of encoding information to long term memory, and the process of retrieving it later, are fallible. That means they do not always work perfectly and information can get lost or be distorted.

Thinking: Exploring cognition

Now that we have a crude understanding of the systems in the brain that could potentially go wrong, let's look at some of the ways in which they do just that.

Biases

Informational-processing biases affect both attention and memory.

Attention is what we pay attention to and we can only pay attention to one thing at a time. Therefore, when we choose to focus on one thing, intentionally or unintentionally, we ignore everything else.

It may be easy to see how this could go wrong: if someone doubts their public speaking ability, their attention may end up focusing on the one person who looks bored rather than the nine people who look engaged. This attentional bias could lead us to mistakenly think we are a poor public speaker.

As we discussed in the previous chapter, our **memory** is often imperfect. Some memories are more available than others, some are misremembered and all are affected by the strength of emotion attached to them.

For example, if you are involved in a car crash, that memory may be more readily available due to the emotion involved and frequent access. All of the times you have driven and not been in an accident do not come to the surface. This memory bias leads us to think that driving is more dangerous than it is.

Once we form such as belief, the brain then seeks additional evidence to confirm this. We look around for other people who are bored or keep an eye out for traffic collisions in the news. This *confirmation bias** reinforces our existing biased beliefs.

Intrusions

Intrusions can take the form of:

- Obsessions
- Negative automatic thoughts
- Flashbacks
- Hallucinations

Intrusions are not necessarily harmful as it depends on how we react to them.

For example, if someone angers us, many of us feel like we would like to give that person a good slap. And the thought does not bother us because we know that we would never do such a thing. It is simply a thought.

But some people may experience *thought-action fusion* where they feel that by

having the thought, they are likely to act on it. This may or may not be the case but can feel very uncomfortable.

Interpretations

The way we interpret the world makes a big difference.

Imagine a dog comes running up to us. If we believe that dogs are friendly we probably think "this lovely dog wants to say hello". But if we believe that dogs are dangerous and will try to bite us, we will have a very different reaction. It is the same situation interpreted in two different ways.

Or imagine we walk past a friend on the street and they ignore us. If we believe our friends like us we are likely to interpret that as "they were distracted and did not see us". However, if we are struggling with depressive thoughts we may interpret that as "our friends do not like us". Again, it is the same situation with two different interpretations.

Where do our interpretations come from? A number of factors. The first is **information-processing biases**. Where does our attention focus on and what memories can we recall?

They are affected by our **core beliefs**, which will be discussed in more detail below.

And they are affected by our **behaviour**. We like to be rational so if we run away from the dog we will start thinking "the dog *must* have been dangerous because I ran away from it".

ABC model

The idea that the consequences (anxiety, depression, etc) are a result of the world as filtered through our beliefs is the basis of the ABC model.

Albert Ellis, creator of _Rational Emotive Behaviour Therapy (REBT) created the ABC model to illustrate this point. It looks like this:

Activating event -> **B**eliefs -> **C**onsequences

The activating event is the dog running up to us or our friend ignoring us on the street. This event itself does not cause us any distress. It is only when we interpret this event through our beliefs that it becomes distressing.

Cognitive distortions

Sometimes our interpretations are accurate. However, sometimes they are not and these *not* times often fall into predictable patterns. Knowing and recognising these patterns is useful because it allows us to spot when we are thinking based on feelings rather than facts.

Thinking error	**Description**
All-or-nothing thinking	Thinking in absolute terms like "I am totally worthless" or "I will never make friends"
Persistent doubting	Continuing to doubt despite a lack of evidence, such as believing our friends do not like us even though they keep being friendly towards us.
Catastrophising	Imagining the worst-case scenario.
Jumping to conclusions	Assuming the worst is going to happen before it does.
Mind reading	Assuming we know what another person is thinking when there could be many possible explanations.
Living by fixed rules	Following "must" and "should" statements.
Negative focus	Ignoring the positives and focusing on the negatives of each situation.
Intolerance of uncertainty	Requiring an unrealistic standard of proof.

Core beliefs

Core beliefs are wider more abstract beliefs that describe our fundamental views of ourselves and the world. These can be adaptive or maladaptive.

The first category of core beliefs is **internal belief** about ourselves.

Adaptive	**Maladaptive**
I am competent	I am less than
I can handle most situations	I cannot cope
I am a good person	I am a bad person

The second category is **meta beliefs** that describe our thoughts about thoughts and thinking patterns.

Adaptive	Maladaptive
I am allowed to relax	Worrying keeps me safe
I can change	I cannot change

The third category is **external beliefs** about the world.

Adaptive	Maladaptive
The world is usually safe	The world is dangerous
People are usually nice	Other people should not be trusted

Controllable cognition

As well as the automatic and semi-automatic processes described above, we have thought processes we can control. Note that I say *can*. When we talk about worry and rumination, it often happens on auto-pilot and it can be difficult to turn this off. But we have more direct control over it than we do of our intrusions or core beliefs.

Rumination

Rumination is thinking deeply about something and typically with depressive disorders, we are describing an unhelpful process of dwelling on negative thoughts.

Typically, this is a result of trying to think our way out of low mood. We may have a thought "why does nobody like me?" and withdraw from society to try and answer the question so that we can fix it. In reality, this rumination maintains our depressive symptoms and we would be better off getting out of bed and *doing* our way out of it.

When we ruminate, we draw further attention to how we are feeling, and this reinforces the negative feelings.

Worry

If rumination is the mechanism that maintains depression, worry is the mechanism that maintains anxiety.

Worry could be described as a coping mechanism to deal with anxiety. When we feel anxious, we try to worry our way out of it, considering all of the possibilities and trying to problem-solve everything that could go wrong.

Unfortunately, this never works because there are always more things to worry about and our mind can always invent new things if we run out.

Second, by engaging in worry and thinking about all of the things that could go wrong, we reinforce the idea that the world is a dangerous place and that we need to worry to keep ourselves safe, reinforcing the patterns of worry.

Thought suppression

When we try to block a thought from our mind and crowd it out with other thoughts, we are engaging in thought suppression.

This is common in OCD where we may worry that having a thought will lead us to commit an action we do not want to. It is also common in PTSD where distressing intrusive thoughts continue to reoccur.

Thought suppression is unhelpful because we if never engage in the thoughts, we never give ourselves the chance to learn that we can cope and that the thought is not as dangerous as we imagine.

Feeling: Exploring emotion

Anyone who has experienced mental health difficulties is fully aware that it is not "all in our heads". There are physiological sensations. In anxiety, this may be sweating, rapid heart rate and trembling. In depression, fatigue, heaviness and sadness.

As we learnt about earlier, these are driven by chemical changes in the body. This should not be confused with *chemical imbalance theory* that suggests anxiety and depression are caused by the chemicals. Merely that these changes are real and measurable.

Stress response

When the body detects a threat, it actives the stress response. This is also known as the fight or flight response. It is perfectly natural: if you see a tiger, you need to

fight it or run away. It keeps us safe.

The stress response releases adrenaline, noradrenaline and cortisol into our system and prepares the muscles for action, diverting blood flow away from non-essential systems such as digestion.

If all this is natural, when does it become maladaptive?

The answer is that when are chronically anxious, the stress response is firing despite there being no threat. For example, giving a speech or being in a confined space poses very little danger. But our body interprets it as a dangerous situation and goes into fight or flight mode.

A key takeaway here is that it is not the stress response itself that is faulty: it is the body's threat detection system that is misfiring.

Lazarus & Folkman model

When does the body fire the stress response? According to the Lazarus & Folkman (1984) model, it is a two-stage process that asks the question:

1. Is this situation a threat?
2. Do we have sufficient coping mechanisms?

If the situation is not a threat, everything is fine. And if the situation is a threat but we have the necessary coping mechanisms, things are also fine. For example, a pilot landing a plane: that is a deadly situation if you get it wrong. But because the pilot has many hours of training, they can land the plane calmly.

However, if we appraise the situation as a threat and we feel that we do not have sufficient coping mechanisms, the stress response activates.

Note that it is our appraisal that is important. It does not have to be objectively dangerous. For example, few people would suggest a banana is a danger. But if you have a banana phobia, that is how you appraise it.

Classical conditioning

The stress response explains how our thoughts can affect our feelings. But sometimes we experience feelings without any obvious thoughts. In this case, classical conditioning may be to blame.

Classical conditioning's most famous example is *Ivan Pavlov** and his dogs. When

we see food we begin salivating in anticipation. This is an *unconditioned stimulus* that occurs naturally in both dogs and humans.

Pavlov paired this by ringing a bell every time he fed his dogs. The dogs learnt to associate the bell with being fed and after many repetitions, the dogs would salivate at the ringing of a bell, even if there was no food present. The bell was a *conditioned stimulus*.

Humans may be smarter than dogs but the same conditioning works on us. For example, imagine struggling with social anxiety. Each social situation triggers negative thoughts which then cause us to feel bad. Soon, just going to a social situation is associated with negative feelings even though there are no apparent thoughts.

Doing: Exploring behaviour

Behaviours are the things we do rather than think and feel. Some behaviours are maladaptive because they maintain the symptoms we are experiencing in the long run. For example, staying in bed with depression, avoiding a situation with anxiety or continuing to use with addiction.

Note that these behaviours are often **functional**: they make us feel good in the short term. If you get a bad feeling when you go into a busy shop, escaping will make you feel good in the short term, even if it maintains the anxiety in the long term.

Similarly, if you are struggling with alcohol abuse, it is probably because alcohol makes you feel good at the time, even if it has consequences later on.

We can classify behaviours are **excesses** (things we should do more of) and **deficits** (things we should do less of. With addiction, using is an excess: we should do less of it. With depression, interacting with other people is usually a deficit: we should do more of it.

Behaviours are learnt. When we burn ourselves on a hot stove we learn not to touch it again. Similarly, when we have a panic attack on public transport, we learn to avoid public transport. This is good news because if it is learnt, we can also unlearn it.

Operant conditioning

Operant conditioning is an associative learning process that explains why we may pick up some of these behaviours.

B. F. Skinner popularised the idea with his Skinner boxes: animals would press a lever and receive either some food or an electric shock. Those that received the food learnt to press the button more while those that received the shock decided they would rather not press it again.

Something that increases a behaviour is a **reinforcer** while something that decreases a behaviour is a **punishment**. But these can also be adding something (positive) or taking something away (negative).

Let's look at some examples to make that clearer:

- A child does their chores so they receive a piece of chocolate. We are adding the chocolate (positive) and it increases the behaviour (reinforcement)
- A child performs their chores so the parent stops nagging them. We are removing the nagging (negative) and it increases the behaviour (reinforcement)
- A child draws on the wall so they get shouted at. We are adding the shouting (positive) and it decreases the behaviour (punishment)
- A child draws on the wall so they lose access to their toys. We are removing the toys (negative) and it decreases the behaviour (punishment)

Now that we have illustrated each iteration, let's look at what this may look like in the context of mental health.

- Jane is struggling with body issues engages in purging. The purging is added (positive) and makes her feel better so they do it more (reinforcement)
- Andy has a panic attack in a busy shop. He uses an escape behaviour to remove himself from the situation (negative) and then makes him feel better so he escapes more often (reinforcement)
- Sam lacks social confidence and when he tries to engage people in conversation they make dismissive comments. The comments are added (positive) when he tries to engage people so it makes him do it less often (punishment)
- Alice takes her medication but as a result, she is deemed "not ill enough to

continue receiving support. The support is withdrawn (negative) so it makes her less inclined to take her medication (punishment)

Note that we should not infer intentionality in these scenarios. Sam may think "what's the point if people are going to be mean to me", but he may also simply act on feelings without noticing it happening.

Avoidance

Avoidance is a feature of many different conditions. For example, with social anxiety, we often learn to avoid social situations because they make us feel uncomfortable. Unfortunately, doing so deprives us of the opportunity to learn that the situation is safe and it is our threat detection system misfiring.

Or consider a couple that is arguing a lot. They learn not to talk to each other because it usually leads to an argument. But this deprives them of the opportunity to work through their issues constructively.

Therefore, avoidance is a maladaptive behaviour because it maintains the symptoms in the long term.

Skill deficits

Sometimes a behaviour is linked to a specific skill deficit. The two we will discuss here are social skills and problem-solving skills.

If we have a **social skill deficit** such as a lack of good communication skills we are unlikely to feel good in social situations and may therefore avoid them. Or, if we struggle to communicate our emotions, it may come out as anger instead.

If we have a **problem-solving skill deficit** we may struggle to make effective decisions or stick with them once we have made them, which can lead to a cycle of worry and rumination on what we should do.

Therapeutic alliance

So far, we have discussed CBT's model of the world: what is going wrong. From this point onwards we will begin to answer the next question: what do we do about it?

This starts with the process of being a therapist. Therapy is a helping relationship, so how do we provide that help? This is relevant for professionals, helping in a non-expert capacity (friends, family) and even when working on ourselves. Indeed, it may be especially relevant when working on ourselves as we are often our harshest critics.

What is the alliance and do we need it?

The therapeutic alliance, also known as the therapeutic relationship, is the relationship between client and therapist. The strength of this relationship is a major factor in the success of therapy.

Therefore, to ask the question "do we need it" seems redundant. But the question is not quite as simple.

In *person-centred counselling*, the therapeutic alliance is the mechanism of action that allows a client to get better. "All" a therapist has to do is provide a useful relationship and the client will improve. I put all in quote marks because providing such a relationship is not easy!

In CBT, we also bring in the cognitive model, understanding of how the mind works and a series of behavioural strategies to make changes. Therefore, some may ask, "do we really need the relationship if we have all of this technology?"

My view, based on years of clinical experience, is that CBT works best with a strong therapeutic alliance. If we are going to ask clients to make difficult changes in their lives, they need to have a high level of trust in us. In some ways, it is *more* important in CBT because we are asking people to make changes, and they will not tolerate the distress often associated with these if they do not believe in their therapist.

Non-specific factors

One of the quirks of different modalities (schools) of therapy is that they all work at a similar rate. CBT typically produces results faster but many others catch up in the long term. Why is this?

Frank (1974) suggested there were a series of common or "non-specific" factors that made therapy work. Grencavage and Norcross (1990) compiled a list of these:

1. Therapeutic alliance

2. Opportunity for emotional relief
3. Acquisition and practice of new behaviours
4. The client having positive expectations
5. The therapist being a source of positive influence on the client
6. Provision of rationale for the client's difficulties

Active listening

Being a good therapist, of any type, starts with active listening. This is often described as "listening to hear rather than listening to respond".

When we are in the pub with our friends, we often use the time that they are talking to think up our next anecdote. This is fine. We are all having a good time over a few beers or lemonades and nothing important will be missed.

But this is very different to being sat in a room with a client who may be pouring their heart out. Here, every word becomes vital.

To do this, we need to give the client our full attention. It also means we need to delay responding until we have processed everything we have said. New therapists often feel uncomfortable with silence and that they need to respond immediately. This adjustment to be able to hear, pause and think takes time to become comfortable with.

We also want to demonstrate our active listening so that the client knows we are paying attention to them. We do this with body language, minimal encouragers (yeah, umm-hmm, okay), and by asking clarifying questions to make sure we understand.

Core conditions

The core conditions are the basic things you need to provide to offer a helpful relationship. This comes straight from *person-centred therapy* and we will not discuss it in all of its details in this course. But I will outline the core principles here because it is relevant to all modalities.

There are three core conditions:

Empathy is seeing the world from the client's viewpoint, also known as their *frame of reference*. Empathy is not sympathy but rather learning to walk in the other person's shoes. For example, if I mostly received Cs in school I would

probably be pretty happy receiving a B in an exam. But if I was from a high-achieving family where my parents expected me to get an A every time, it would be a big disappointment. We can only appreciate those emotions if we use the correct frame of reference.

Unconditional positive regard (UPR) is accepting the other person without judgment. It is letting go of our values and respecting the person in front of us. That does not mean we need to *like* them. But by accepting them for who they are, we role-model this acceptance for the client and they begin to accept themselves. Self-acceptance is the first step to making changes: it is very difficult to change anything if you are in denial about your feelings!

Finally, **congruence** is genuineness. It is about being ourselves rather than putting on an act. After all, who would want a relationship with someone who was being fake?

Formulation

Formulation, in simple terms, is what is going wrong.

Formulation is an alternative to diagnosis. When we diagnose someone with a specific condition, we give them a label ("you have OCD"). This can be helpful but it can also be unhelpful as people can incorporate this into their identity and it encourages us to treat it like a medical condition rather than seeing the person in front of us.

To avoid this trap, we can use formulation. This focuses on the individual and the problem at hand: what are they struggling with right now that we can change? It has the advantage that it is more fluid and can change over time and that we can co-construct our formulation with the client.

Psychoeducation

Here, CBT and person-centred go their separate ways somewhat. Person-centred is non-directive: the client sets the agenda and the therapist never offers advice.

In CBT, we work with the client to help them find a solution to their problems. This may involve some suggestions and education from the therapist on how the cognitive model works and how the client can better understand themselves.

Does this mean we, the therapist, set the agenda and lecture the client? Certainly

not. But education is an important aspect of CBT. This can often be achieved through conversation. Consider the following client struggling with depressive thoughts:

> *Client: I have the thought that I am worthless, and then I think what's the point as I can't change, so I just stay in bed. Therapist: I wonder if everyone has these thoughts. What do you think? Client: I guess so. Therapist: Okay. Other people don't stay in bed, though. What do you think is different for them?*

Doing CBT

Once we have established how we are going to engage with a client, it is time to think about *what* we do. While every course of CBT is different, a rough overview may look something like this:

1. Assessment
2. Active listening
3. Formulation
4. Set goals
5. Make changes
6. Review results
7. Repeat
8. Generalise findings
9. End therapy

Therapy starts with an assessment and if CBT is a good fit for the client, we then invite them to explain the difficulties they are having. This is an excellent chance to provide some emotional relief. As they open up, we develop a formulation together about what is going wrong.

Once this is complete we agree on some goals to work towards. We then begin implementing changes (also known as interventions) to help us achieve these goals and review the results after each round of changes. This process is typically repeated many times.

As we continue to make changes, review and repeat, the client begins to spot patterns such as cognitive distortions and begins to generalise these results to

the rest of their life. Once the goals of therapy have been achieved, it is time to end the therapy.

Assessment

Everything starts with an assessment. This consists of two parts, a diagnostic assessment and a therapeutic assessment.

A **diagnostic assessment** looks at what is going wrong and typically comes with a label of anxiety, depression, OCD, etc. While we typically prefer *formulation* while doing therapy, this can be a helpful starting point. A client may come in with a diagnosis from a doctor, but the more common mental health conditions can also be diagnosed with inventories (questionnaires) and we will discuss these in more detail in the *conditions* chapter.

Next, we should do a therapeutic assessment to see whether CBT is a good fit for the client or whether we should signpost them to a different type of therapy.

If the client has a diagnosis, a good place to start is the American Psychological Association's Division 12 website that lists the common mental health conditions and the evidence-based treatments for each.

For example, let's say a client comes in with OCD. We could look up obsessive-compulsive disorder on the Division 12 website and find out that CBT is listed as a suitable treatment with a strong evidence base.

If we have no such label to work with, the following table may be helpful in making such an assessment:

Good fit	**Consider alternatives**
Acute problems	Chronic problems
Clear goals	Refusal to commit to goals
Likes structure	Dislikes structure
Happy with homework	Wants to do it all in therapy
Positive expectations	Negative expectations

That is not to say CBT *cannot* work in these cases. But they are indicators that a different type of therapy may be beneficial for the client.

It is also worth considering that some clients may not be ready for *any* kind of talking therapy. The following table looks at some of the common requirements for most talking therapies.

Common requirement	May not be ready for therapy
Willing to trust therapist	Not willing to trust
Able to build an alliance	Inability to build an alliance
Able to express feelings	Unable to express feelings
Positive expectations	Negative expectations

Note that "positive expectations" is in both tables on purpose. It is important for all talking therapies but especially important in CBT.

Case formulation

Once we begin a course of therapy, it is time to put our listening ears on and begin building the therapeutic alliance. As we do this, we can begin to conceptualise the problem and build our case formulation.

It is important that the client understands and agrees to the formulation as this provides the rationale for the client's difficulties: it explains to them what is going wrong so that they can understand how to change it.

Setting goals

CBT is goal-oriented: by the end of therapy we want the client to behave or feel differently and unlike other modalities, we want to know what that is from early on so that we have something to work towards.

This could be:

- Going back to work
- Feeling less depressed
- Reducing drinking

Or anything else that the client would like to towards. Note then that the client sets the goal, but as a therapist, we want to encourage them to set one that is clear, measurable and achievable: think SMART goals but without the time component.

Making changes

Once we have set our goals we can start making changes to achieve them. CBT uses a series of interventions where we think or act differently and we will discuss

these in the coming chapters.

Overall, behavioural changes are typically the most important as these will make the biggest changes to how a client feels. However, I typically start with cognitive changes because they produce small but rapid changes, allowing us to take some easy wins in the first few sessions before settling into the more difficult behavioural work.

Homework

Progress in CBT often happens outside of the therapy room. sessions involve reviewing homework completed since the last session and agreeing on tasks to completed before the next session.

What does this homework involve? **Learning** could involve reading about any relevant conditions, the cognitive model and different strategies to implement.

Self-monitoring could include keeping a thought diary to help us notice patterns and cognitive distortions.

Making changes includes practising cognitive and behavioural strategies to think or act differently.

Cognitive strategies

Cognitive strategies are about *thinking* differently. This starts with exploring our thoughts in more depth.

A "fun" game to play here is "why's that bad?" where we attempt to drill down into a thought to find the root cause. For example, imagine we are having the thought My friends invited me to the pub but I don't want to go".

What is going on beneath the surface? Is it that we worry our friends do not really want us there? That pubs are crowded and noisy? That we will be peer pressured into drinking alcohol? Or judged for not drinking alcohol?

Challenging thoughts

Once we understand why we find a thought uncomfortable, we can examine its truth value. We can do this by asking a series of questions:

1. Is it likely?
2. Is it serious?
3. Are there any thinking errors?

For example, let us say we have been invited to a party and identified the thought "I will do something really embarrassing, everyone will laugh at me, and I will lose all of my friends"

Is it likely? Probably not. Most of the time we do not embarrass ourselves. It could happen, but it probably won't. And even if we did embarrass ourselves, everyone would probably laugh it off and forget about it.

Is it serious? No. Even if we did embarrass ourselves, it would be distressing at the time but we are unlikely to come to any physical harm because of it.

Are there any thinking errors? Yes, we're jumping to conclusions (I *will* embarrass myself) and catastrophising (that will lead to me losing all of my friends).

Rewriting thoughts

On top of challenging thoughts, we can also rewrite them. This involves giving them a positive spin while still keeping them believable.

Original thought	**Rewritten thought**
I will have a panic attack at the cinema.	I may have a panic attack, but it may not happen, and either way, I will get to see the film I want to see.
My friends do not like me.	I feel like my friends do not like me but they must like me at least a little as they keep inviting me out.
If I allow myself to have violent thoughts I will act on them.	These violent thoughts are uncomfortable but I have never acted on them before.

Experiments

One way to test if a thought is true is with an experiment. For example, we may be invited for a social with our friends but feel like we would feel uncomfortable and unhappy the whole time. This is a good thought to test with an experiment.

Beforehand, we can write down our prediction.

"I think I will feel uncomfortable and not enjoy the evening."

After (or even during) the event we can record our thoughts and feelings about what happened. Typically, it is something better than predicted.

"I felt uncomfortable at first but then my anxiety went down and I enjoyed the second half of the night."

By doing this we show ourselves that our thoughts are based on feelings and not facts. We expect to have a bad time because our cognitive distortions lead to a negative bias, not because that is representative of reality.

Tackling interpretations

Challenging individual thoughts will gradually show us that our thinking is biased. This will lead us to consider whether our interpretations are also biased and whether we should consider alternative explanations.

For example, let us say our spouse has not returned home at the usual time.

We may fear they have been involved in a car crash and badly hurt. This is one explanation but is unlikely. Therefore, we can ask ourselves "what are the alternative explanations?"

- They are working late
- They are stuck in traffic
- They decided to walk home
- They have gone to the stops on the way home

Thought diaries

Thought diaries allow us to keep track of our negative thoughts and interpretations. Each time we have such a thought we can record where we were and the thoughts, feelings and behaviours associated with it.

Having this record allows us to begin spotting patterns: does a certain thought always lead to an unhelpful behaviour? Do we always interpret a certain feeling a certain way? Patterns are useful because it suggests we are working on auto-pilot rather than looking at the facts. It also provides us with a variety of thoughts, feelings and behaviours to work with during therapy sessions.

Behavioural strategies

We often assume that our feelings and behaviours are driven by our thoughts. But, as we have learnt, our thoughts, feelings and behaviours are all interconnected so we can also change our behaviour to change our thoughts and feelings.

The implication of this is that we do not need to *feel* better to change our anxiety and depression. We can also *do* things differently and wait for the feelings to follow.

Exposure

Exposure is the process of desensitising ourselves to an unpleasant stimulus. This can sound scary. If you have a banana phobia and I tell you "I need you to touch a banana" in our first session, you are rightly going to be sceptical!

But if I explain that we will take small steps that you feel comfortable with and only do it when you feel ready, it would probably sound more manageable.

Exposure can be done in several ways:

- Real-world exposure involves doing it out in the field
- Imaginary exposure involves using mental imagery to do it in our minds
- Photos and videos
- Exposure to thoughts involves releasing our thought suppression and allow ourselves to experience disturbing thoughts
- Physiological involves trying to create the symptoms, such as trying to trigger a panic attack

A key part of exposure is that it should be **graded**. This means breaking the down into many sub-tasks with an associated level of distress.

Task	**Score**
Hold a spider	100
Spider in a room	80
Spider in a class case	70
Video of a spider	50
Picture of a big spider	40

Task	Score
Picture of a small spider	30

We can use our hierarchy to take small steps at a time. Each task can be repeated as many times as needed until the distress subsides to a manageable level. What is manageable? Typically around 30. It is unlikely to disappear completely so at this point we should move onto the next task.

When performing a task we want to do so mindfully. That is to say pay attention to your thoughts, feelings and the situation. If we distract ourselves, we are not properly being exposed to the stimulus.

Waiting for distress to come down can be a slow game. Several studies indicate it can take 40-45 minutes for distress to subside.

If we get stuck there are several things we can do to troubleshoot:

- Continue repeating the activity
- Add more levels (smaller steps)
- Increase the frequency to daily if possible
- Change context variables like location and support

Safety behaviours

Safety behaviours are things we do to make ourselves feel better. This could be always carrying our phone, checking where the emergency exits are or always unplugging an electrical device to ensure we cannot leave it switched on.

Safety behaviours are unhelpful because if we are trying to teach ourselves that a situation is safe, we are giving ourselves a “because” get out. It was safe “because” I checked the emergency exits. Therefore, we should remove safety behaviours where possible. If required, this can be incorporated into the hierarchy.

Pleasurable activities

So far in this chapter, the behavioural changes have been unpleasant: taking a situation we fear and allowing ourselves to experience it.

But not all homework is this way. Sometimes we may agree with a client to engage in pleasurable activities.

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For example, with depression, we often forget to engage in self-care and stop doing the things we like. A good homework may therefore to be reengaging in an old hobby. We may not *feel* like doing it, but we know we can change feelings with behaviours.

Or maybe a couple that constantly argues agrees that they will start doing date night where they deliberately spend more time together doing things they enjoy.

Triggers

Sometimes a chain of events is caused by triggers of cues.

For example, a client who is struggling with alcohol use may find that when they spend time with certain friends at a set location they end up drinking. The friends would be a positive cue to use alcohol and they may need to spend less time with these friends to modify their alcohol use.

Or maybe a client with health anxiety is constantly reading the news and seeing items about diseases and accidents around the world. Reading the news is a negative cue for worrying about their health and they made need to stop reading the news to improve their health anxiety.

Do not confuse triggers with avoidance. If we are avoiding a situation due to perceived distress that is something we should tackle.

Skills training

If a client is engaging in behaviours because of a skill deficit, skills training can help them develop these abilities and act differently.

The first step is a skill assessment: is there a deficit that we can work on? Self-report measures are typically unreliable here because people with low self-esteem tend to underestimate their abilities.

Seeking the opinions of others (friends, family) can be a good starting point but often we need to make the assessment ourselves through talking to the client, examining the topics that come up in therapy and role-playing.

Once we have agreed to work on a skill deficit there is a four-stage process to acquiring the skill:

1. **Instruction**. The therapist describes the skill to the client in easy-to-understand steps.
2. **Modelling**. The therapist uses the desired skill in the therapy session and discusses its use in the outside world.
3. **Practice**. The therapist role-plays with the client and provides immediate feedback.
4. **Homework**. The therapist and client agree where the client will practice the skill in the real world.

Social skills

Social skills have a wide variety of applications. Social anxiety is the obvious example but it is important to note that social anxiety can be a result of a perceived lack of social skills rather than a genuine deficit.

Self-esteem and assertiveness also fall under social skills and are often issues with depression. Lack of assertiveness (the ability to say no) is a problem with addiction. Being unable to communicate emotions is typically a feature of relationship issues and anger management.

The key skills to develop are:

- Verbal communication
- Non-verbal communication
- Assertiveness
- Active listening

Problem-solving skills

Problem-solving skills can be a feature of anxiety, depression and a variety of other issues. Poor problem solving can involve:

- Poorly defined problem
- Few solutions
- Impulsive decision making
- Inability to make a decision or stick to a decision

The key skills to develop are:

1. **Define**. A clear and concrete definition. Step back and take a moment to

detach from the emotion.

2. **Generate**. Multiple possible options without getting caught up in the first solution.
3. **Decide**. Make a decision based on feasibility, short-term and long-term consequences.
4. **Act**. Implement the decision and review the results.

Mental health conditions

In this chapter, we will look at some of the common mental health conditions and how CBT is best applied. Note that these are starting points to begin our formulation and not rigid structures to be followed.

Depression

Depression is a period of low mood or lack of enjoyment that lasts more than two weeks.

Typical features include thoughts of hopelessness, worthless and low self-esteem. Feelings are tiredness and heaviness. Behaviours may include staying in bed and withdrawing from society.

Common assessment tools include the PHQ-9 and Beck Depression Inventory.

Start by exploring the thoughts, feelings and behaviours. A key feature here is to get the client *doing* something different by showing them that doing nothing and trying to *think* their way out of it is not working.

Experiments can be useful because a client will often feel they do not want to do anything but will feel better when doing something. Using the experiment worksheet will help demonstrate this.

Generalised anxiety disorder (GAD)

Generalised anxiety is a level of background worry that a client experiences most days.

GAD is a difficult form of anxiety to treat because there is often a lack of targets. Thoughts are varied and tackling one often leads others to appear. Worry is

typically a major component.

The most common assessment tool is the GAD-7.

Start by exploring thoughts, feelings and behaviours. Although challenging individual thoughts often leads to others, if this is repeated enough the client may generalise this process to all of their worries.

Changing behaviour is also useful because clients typically try to *think* their way out of anxiety rather than *acting* differently. Strengthening problem-solving skills can also be useful to help clients make more decisive decisions rather than enter a cycle of worry.

If all of this is unsuccessful, consider other therapies.

Phobias

A phobia is an overwhelming or debilitating fear of an object. Clients will often organise their life around avoiding the object or situation. Common phobias involve animals, claustrophobia and agoraphobia.

A phobia is an over-estimation of the risk of a particular situation which can often lead to a panic attack. It is highly distressing but not physically dangerous.

Phobias are highly treatable and clients can make a full recovery. Graded exposure is the best tool.

Panic disorder

A panic attack is a sudden attack of anxiety or panic. They are intense and highly distressing but not physically dangerous. If a client experiences these regularly and begins to live in fear of the next panic attack, this is panic disorder.

A common assessment tool is the Panic Disorder Severity Scale (PDSS).

Panic attacks typically last 5-20 minutes. They often have triggers and clients may alter their life to avoid these triggers.

Start by exploring the situations and feeling around panic attacks. Often a client feels like they are going to die and some education around the physical effects (or lack of) panic can be useful if done in an empathic manner.

The attacks themselves are typically hard to control so we want to focus on how we respond to them. Giving a client better coping mechanisms (for example,

breathing techniques) can help reduce the fear.

If the client wishes to try it, physiological exposure where we try to induce a panic attack in the therapy room can be useful to further reduce the fear by taking control of the situation. Exposure outside of the therapy room can then follow this.

Social anxiety disorder (SAD)

Social anxiety disorder, also known as *social phobia*, is a fear of social settings. Typically fears around embarrassment and humiliation or judgement by others.

This could manifest in speaking to other people, public speaking and attending social events, or a variety of other social situations.

There may also be issues around self-image and appearance.

Social anxiety can be assessed using the Social Phobia Inventory (SPIN).

Start by exploring thoughts, feeling and behaviours around problem situations. Use graded exposure to tackle avoidance and test predictions with experiments. This can help challenge interpretations. Mind reading is a common cognitive distortion.

In some cases, there may be a social skills deficit or issues around assertiveness and social skill training can play a part.

Obsessive-compulsive disorder (OCD)

Obsessions are unwanted thoughts or intrusions. They may exist on their own (a condition known as *Pure O*) or be paired with compulsions that can be covert (for example, counting in our heads) or overt (for example, washing our hands).

OCD can be assessed using the Obsessive Compulsive Inventory (OCI) or using the shorter Obsessive Compulsive Inventory - Revised (OCI-R).

Intrusions are difficult to control so the way we respond to them is typically a better treatment target. Let's take the stereotypical OCD issue of repeatedly washing our hands. The thought is "my hands are contaminated" which makes us feel bad and so we engage in a washing ritual to make those feelings go away. Unfortunately, as we imagined the problem, how much washing is enough?

People struggling with OCD sometimes engage in thought-event fusion and

thought-action fusion. Thought-event fusion conflates having a thought with it being likely. For example, many of us may occasionally have the thought that our spouse has been in a car crash. But we find it easy to dismiss as unlikely. Someone struggling with thought-action fusion would not.

Similarly, thought-action fusion conflates having a thought with acting upon it. It is not uncommon for thoughts to be around violence and sexual assault. Again, many of us would find these thoughts easy to dismiss. But someone struggling with thought-action fusion may engage in thought suppression because they fear they would act on them.

How we react to thoughts typically make the best treatment targets. We can challenge these thoughts and use graded exposure to tackle avoidance and thought suppression. Considering alternative explanations is useful with thought-event fusion. We may also look at triggers.

CBT seems to be effective for around half of OCD sufferers. That means that for the other 50% it is not particularly effective and for such clients, we should consider alternative therapies.

Post-traumatic stress disorder (PTSD)

Traumatic events are where we feel our life is in danger. It is normal for symptoms to persist for several weeks after such an event but if they remain for more than four weeks it comes post-traumatic stress disorder.

PTSD is typically diagnosed using a structured interview rather than an inventory.

People struggling with PTSD may repeatedly re-experience the event, experience fear, hopelessness and horror, and engage in thought suppression or avoidance of any triggers that cause them to re-experience.

Sometimes clients will deliberately re-experience the event to engage in gap-filling: attempting to build a complete memory of the event to allocate blame and work out what they should have done differently to keep themselves safe. This is often a trap because our memories are never perfect.

When treating PTSD with CBT, we do not need to explore the trauma in detail. Instead, we should focus on the symptoms and effects. This could include exploring any suppression, avoidance, hypervigilance to threats and any thoughts and feelings that originate from this, such as the fear of losing our mind or going crazy.

Insomnia

Insomnia is a difficulty in falling or staying asleep, often accompanied by feelings of tiredness and irritability. It often accompanies other conditions.

Insomnia can be assessed using the Insomnia Severity Index (ISI). A separate version of CBT known as *Cognitive Behavioural Therapy for Insomnia (CBT-I)* has been developed.

Behavioural and environmental changes can be useful. One factor is *sleep hygiene*. Ideally, the bedroom will be a space that is only used for sleep (and sex). That means no TV, no working, no other activities in there as we want the room to be associated with sleep.

Keeping the room quiet and cool are also helpful, and implementing bedtime routines to condition the body to fall asleep.

Another important factor is what we do when we cannot sleep. It is common for clients to lay awake for hours thinking "I need to be asleep now just to get four hours sleep". This is unhelpful because it teaches us the bedroom is a place where we do not sleep.

A better behavioural strategy is to get out of bed if you cannot sleep and do something else, then return to bed when you are tired. it may seem counterproductive to get out of bed when you are trying to sleep but forcing ourselves to sleep rarely works and is unhelpful in the long term.

Addiction

Addiction is a lack of control over something you are doing or taking. This is often drugs, alcohol and nicotine (which are both drugs, of course) and gambling, but can involve a range of other behaviours.

Most addictions are covered by specialist support services who should take the lead in assessing people, but self-reporting is also common.

Typically, the specialist support service will manage the treatment of the addiction but therapy should be done at the same time to address the underlying issues. Often, addiction is a coping mechanism for a mental health condition such as drinking to alleviate feelings of depression and anxiety.

Start by exploring the motivations for using and uncover any underlying problems. Explore triggers and change the environment if required. Explore the

impulse to use and the client's reaction to the impulse.

Beyond CBT

Cognitive behavioural therapy is a complete therapy in itself and one of the most popular in the world. It has also been extended in several ways, sometimes known as *third-wave CBT* therapies.

In this chapter, we will explore some of the most common. This is not a manual on any of these therapies but provides CBT practitioners with a brief introduction to other available options.

Acceptance & Commitment Therapy (ACT)

ACT was one of the first therapies to integrate mindfulness into CBT. Its philosophy is that we do not need to eliminate uncomfortable feelings but rather accept them without allowing them to limit our life.

ACT is a good option for clients who have become disillusioned with CBT and are willing to accept the feelings may never go away. CBT Is typically the first option but if results are poor, ACT should be considered if the client is comfortable with the ACT philosophy.

Mindfulness-Based Cognitive Therapy (MBCT)

MBCT fuse mindfulness with elements of the cognitive model in an attempt to create a "maintenance" version of CBT.

That means that MBCT is designed to be delivered to clients who are recovering from depression and anxiety and are looking to prevent relapse or reoccurrence in the future.

This makes it a very different kind of therapy in that it is typically delivered to people when they are well and is often taught in a group format as it is modelled on the *Mindfulness-Based Stress Reduction* programme.

It is not suitable for clients who are currently struggling with depression and anxiety.

Metacognitive Therapy (MCT)

MCT is a cognitive-based therapy. Where CBT looks at the content of our thoughts, metacognitive looks at the process of thinking. So, instead of "what" we think it looks at "how" we think.

MCT is most effective in treating persistent worry and rumination. While CBT works well for acute cases and specific phobias, MCT is more suited to chronic anxiety and depression, such as generalised anxiety disorder, where CBT has not been effective.

Dialectical Behaviour Therapy

DBT was originally designed to treat borderline personality disorder and has since expanded to cover a range of conditions where the emotions are particularly intense (for example, PTSD, self-harm, suicide).

It uses emotional regulation, acceptance and mindfulness and typically uses a mixture of individual and group sessions.