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Cognitive-Behavioral Therapy

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Cognitive-Behavioral Therapy

Abstract
Cognitive-behavioral therapy (CBT) is the merging of behavioral and cognitive therapies that mostly focuses on working with the client in the present. Although there are many approaches to CBT, there tend to be some common features. For example, CBT is generally a directive approach to psychotherapy that helps clients to challenge their problematic thoughts and to change the behaviors associated with those thoughts. In addition, most approaches to CBT are structured and time limited and include some type of homework where the client can practice the cognitive and behavioral strategies learned in the therapeutic setting. This entry focuses mostly on CBT as defined by Aaron Beck, one of the early founders of this approach.

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Cognitive-behavioral therapy (CBT) is the merging of behavioral and cognitive therapies that mostly focuses on working with the client in the present. Although there are many approaches to CBT, there tend to be some common features. For example, CBT is generally a directive approach to psychotherapy that helps clients to challenge their problematic thoughts and to change the behaviors associated with those thoughts. In addition, most approaches to CBT are structured and time limited and include some type of homework where the client can practice the cognitive and behavioral strategies learned in the therapeutic setting. This entry focuses mostly on CBT as defined by Aaron Beck, one of the early founders of this approach.

Historical Context

The first approach to CBT to achieve widespread recognition was rational emotive therapy, originated by Albert Ellis in the mid-1950s. Ellis developed his approach in reaction to his disliking of the inefficient nature of psychoanalysis. Ellis believed that how we act and how we feel are the result of irrational thinking, and he proposed a number of typical irrational thoughts that people tend to have that will lead to dysfunctional ways of being in the world (e.g., the need to be loved by everyone on the planet, the idea that we must rely on others for our happiness, etc.). His approach was widely used in the latter part of the 20th century and continues to be used today.

Not too soon after Ellis developed his approach, during the early1960s, Aaron Beck developed a similar approach he called cognitive therapy. Initially applying his approach to those with depression, Beck’s ideas eventually spread to a whole range of other diagnostic categories. Beck stayed away from the use of the word irrational and instead suggested that core beliefs and deep schemas, or embedded ways by which we tend to view the world, lead to dysfunctional behaviors and negative feelings. His approach was outlined in a classic series of articles published in the 1960s. Beck’s early writings focused primarily on pathology in information processing styles in clients with depression or anxiety, but he also incorporated behavioral methods to prevent feelings of helplessness.

After the work of Ellis and Beck, a number of others developed related theories that became widely used. For instance, Max Maultsby developed rational emotive imagery, rational self-analysis, and the five criteria for rational behavior, which included an emphasis on client rational self-counseling skills and therapeutic homework. Another example is Donald Meichenbaum, who developed stress inoculation therapy, an attempt to
integrate the research on the roles of cognitive and affective factors in coping processes with the emerging technology of cognitive-behavioral modification.

More recently, CBT has been influenced by new theories and associated assessment, treatment, and prevention technologies that highlight psychological acceptance and mindfulness. One of the most prominent examples is Marsha Linehan’s dialectical behavior therapy (DBT), which incorporated CBT with mindfulness and balancing acceptance with change. DBT was originally developed by Linehan for clients with borderline personality disorder and related parasuicidal behaviors. It has since been modified for use with other populations, including those with substance abuse and depression.

Today, CBT comes in many shapes and forms and has become a dominant force in psychotherapy in much of the world. This is largely due to the increased focus on evidence-based practice and related demands for accountability in the delivery of mental health services. Throughout its history, CBT has been committed to a scientific perspective to the study of psychopathology and its treatment. Hundreds of studies have evaluated various cognitive-behavioral theories of psychopathology, and hundreds more have assessed the efficacy of CBT interventions.

**Theoretical Underpinnings**

CBT is applied in many different ways today, and all CBT approaches have in common a focus on the cognitive and behavioral aspects of the person. Psychotherapists who use CBT believe that people learn by observing and imitating, as well as through reinforcement. From this theoretical perspective, dysfunction can generally be linked back to childhood experiences, though the approach itself focuses on the here-and-now. In some ways, all CBT approaches attempt to challenge and modify the client’s thinking process and behaviors in an effort to assuage dysfunctional ways of living in the world. CBT posits a two-way relationship between cognition and behavior in which cognitive processes can influence behavior, and behavioral change can influence cognitions. Because cognition and behavior are so closely linked, psychotherapists can opt to intervene at either the cognitive or the behavioral level, using practical methods of interrupting the cycle and encouraging more adaptive responses.

**Major Concepts**

**Cognitive Concepts**

Three major levels of cognition that are often identified in the practice of CBT include (1) full consciousness, (2) automatic thoughts, and (3) schema. Full consciousness is defined as a state of full awareness and optimized judgment. In contrast, automatic thoughts are cognitions that flow rapidly in the stream of everyday thinking and may not be carefully examined for correctness or rationality. Usually out of consciousness, they are readily accessible once a person is made aware of them. Everyone has automatic thoughts, but in the case of pathology such as obsessive-compulsive disorder (OCD) or generalized anxiety disorder, these cognitions are often full of errors in logic. These are called cognitive distortions and include distorted thinking such as overgeneralization, all-or-nothing thinking, mind reading, fortune telling, and discounting the positive, to name a few. For example, someone with OCD might overestimate the risk involved with refusing to engage in a compulsion such as hand washing or checking. Likewise, in generalized anxiety disorder, people might underestimate their ability to cope with a potential threat. For example, someone might choose to avoid holiday shopping altogether because she or he fears how she or he will manage the crowds and parking.

The final and deepest level of cognition defined by CBT is schemas, sometimes called core beliefs. These are a client’s fundamental rules or templates for processing information. Types of schemas include person schemas, event schemas, role schemas, and self schemas. Person schemas are schema about the attributes (skills, values, abilities) of a particular individual. Event schemas, or cognitive scripts, are processes, practices, or ways in which we typically approach tasks and problems. Role schemas contain sets of role expectations or how we expect a person in a certain role to behave. Last, self schemas are generalizations about oneself taken from current and past experiences.
It is important to note that CBT does not say that all negative or painful emotions are bad. Emotions such as fear, anger, and sadness can be very appropriate and even useful. Fear can tell us there is danger, and motivate us to protect ourselves. Anger can inform us that our rights are being violated, and we need to take action to assert our rights. Sadness can be the result of losing something or someone important to us and can indicate that we need to take the time to grieve.

When working with clients, it is important to distinguish between adaptive and maladaptive emotions. Negative and painful emotions can be adaptive if they are based on accurate thinking and guide an appropriate response. Maladaptive emotions are driven by distorted thinking and cause unnecessary suffering.

**Behavioral Concepts**

It is natural to avoid things that are painful or difficult. Up to a point, avoidance is understandable and effective, but it can become problematic if it becomes the primary method for dealing with difficult life circumstances. Unfortunately, these "safety behaviors" tend to maintain problems rather than deal with them.

In behavioral therapy, psychotherapists help clients strategically change behaviors that they typically exhibit in response to schemas and their resulting automatic thoughts and dysfunctional behaviors. At the same time, behaviors that are likely to improve a client's overall well-being are increased. Such behaviors challenge the natural avoidance behaviors that have been developed to maintain the individual's "safety."

In the case of OCD, challenging natural avoidance behaviors might involve "saying no to OCD" or doing the opposite of what you typically would do in response to an intrusive thought. The term for this technique in CBT is exposure and response prevention and is covered in greater detail in the next section. Likewise, in the case of depression, a practitioner using CBT might assign activities to help a client focus on positive goals or accomplishments. This often involves doing things for oneself that one might not otherwise do while in a depressed state. In either case, the goal is to change behavior by bringing schemas that result in dysfunctional behaviors into conscious awareness.

**Techniques**

CBT involves the use of a wide variety of techniques to help people change their cognitions and behavior. Psychotherapists select techniques based on their ongoing assessment of the client and his or her problems, as well as their specific goals. There is no one technique in CBT that is right for everyone.

**Cognitive Techniques**

Cognitive techniques are techniques used in CBT to help clients challenge problematic patterns of thinking. The following techniques are among the most common cognitive techniques used in practice.

**Use of Questions**

The use of questions, an important and frequently used cognitive technique, encourages the client to break through rigid patterns of dysfunctional thinking and to see new perspectives. Socratic questioning involves inquisitive questions that gently challenge the client and guide him or her to become actively involved in finding answers. Socratic questions are often used for the following reasons:

1. Clarification (e.g., "What do you mean when you say . . . ?")
2. Probing assumptions and evidence (e.g., "How can you verify or disprove that assumption?")
3. Questioning viewpoints and perspectives (e.g., "Who benefits from this . . . ?")
4. Analyzing implications and consequences (e.g., "How come . . . is important?")
5. Summarizing and synthesizing (e.g., "What are your reactions to the evidence that we looked at?")

When used skillfully, Socratic questioning can help clients engage in the process of guided discovery. Guided discovery involves a series of questions that help clients reflect on the way they process information. Through this process of answering questions, clients can explore alternative ways to think and behave.

One useful analogy for guided discovery is that of going to an optician for an eye test. The optician will initially have patients look through several
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lenses while removing or replacing some of them. Then, through a process of trial and error, patients begin to see more clearly.

**Journaling**

Often used at the beginning phase of therapy, clients are asked to make notes of their automatic thoughts that occur in stressful situations and to identify emotions associated with these thoughts. As the client gains knowledge and experience with CBT, the journal can be used to help identify cognitive errors embedded in one’s automatic thoughts, generate rational alternatives, and chart the outcome of making these changes.

**Cognitive Restructuring**

Cognitive restructuring refers to the process of replacing cognitive distortions with thoughts that are more accurate and useful. Cognitive restructuring has two basic steps: (1) identifying the thoughts or beliefs that are influencing the disturbing emotion and (2) evaluating them for their accuracy and usefulness using logic and evidence and, if warranted, modifying or replacing the thoughts with ones that are more accurate and useful. CBT emphasizes that this is best done as a collaborative process in which the client is assisted in taking the lead as much as possible. As a result, the psychotherapist refrains from assuming that the client’s thoughts are distorted. Instead, the psychotherapist attempts to guide clients with questions that help them make discoveries on their own.

**Cognitive Rehearsal**

In cognitive rehearsal, the psychotherapist and the client work collaboratively to find ways to resolve a specific problem by “rehearsing” the situation when this problem is most likely to occur. For example, a client might use her imagination to think about having a positive interaction or experience with her new in-laws. She would then, with the therapist’s help, mentally rehearse the steps needed to achieve this outcome.

**Validity Testing**

With validity testing, the psychotherapist challenges the validity of a client’s beliefs or thoughts, allowing the client to defend his or her viewpoint using objective evidence. If the client is unable to substantiate the beliefs, then the therapist points out the error in that client’s thinking.

**Guided Imagery**

Guided imagery refers to the use of vivid or figurative language to help clients relax, meditate, gain confidence, improve mood, gain understanding, and improve future personal performance and development. Guided imagery is considered to be more effective when the person performing it is already in a relaxed state. When using guided imagery, the psychotherapist helps clients find a situation, location, or state of being that can be imagined and called on to help achieve therapeutic outcomes either within or outside of the therapy room.

**Imagery-Based Exposure**

One version of imagery-based exposure involves bringing to mind a recent memory that provoked strong, negative emotions. This also involves labeling the emotions and thoughts experienced during the memory and what behavioral urges were present. Imagery-based exposure can help make intrusive or painful memories less likely to trigger rumination. Psychotherapists use this technique with caution, after ensuring that the client has the coping skills necessary to deal with the negative emotions being evinced.

**Behavioral Techniques**

In CBT, behavioral interventions typically follow the establishment of a therapeutic relationship. Then, behavioral techniques are implemented to reinforce what is being learned from a cognitive perspective. Some of the most commonly used behavioral techniques are listed and described in the following subsections.

**Activity and Pleasant Event Scheduling**

Activity and pleasant event scheduling are commonly used to help depressed clients reverse problems with low energy. They involve obtaining a baseline of activities during a day or week, rating activities on the degree of mastery or pleasure, and then collaboratively designing changes that will
reactivate the client, stimulate a greater sense of enjoyment in life, or change patterns of social isolation or procrastination.

**Graded Task Assignments**

In graded task assignments, problems are broken down into parts and a stepwise management plan is developed. Graded task assignments are used to assist clients in coping with situations that seem especially challenging or overwhelming.

**Abdominal Breathing**

Abdominal breathing refers to the act of breathing by contracting the diaphragm and expanding the abdomen. Abdominal breathing is widely considered to be the most effective way to breathe to reduce stress. With the emergence of new technology, abdominal breathing is sometimes paired with biofeedback to help reinforce clients’ efforts to self-regulate.

**Exposure and Response Prevention**

Exposure and response prevention is the process of strategically exposing a client to a feared stimulus (e.g., dirt) and supporting her or him in avoiding typical behaviors performed in response to that feared stimulus (e.g., washing hands). This is considered to be one of the most effective behavioral techniques. Exposure protocols can be either rapid or gradual. Typically, a hierarchy of exposure experiences is developed, with sequential increases in the degree of anxiety provoked. Clients are encouraged to expose themselves gradually to these stimuli until the anxiety response dissipates and they gain a greater sense of control and mastery. Progressive relaxation and abdominal breathing exercises may also be used to reduce levels of autonomic arousal and support the exposure protocol. Cognitive rehearsal is often used to prepare for exposure and response prevention.

**Writing in a Journal**

Also called a “thought record,” clients write down their thoughts so that they can analyze them, often with a psychotherapist. This gives clients a chance to reflect on their thinking after an incident, when they are not reacting out of fear or anger. For this reason, journaling can be used to help with both behavioral and cognitive outcomes.

**Systematic Positive Reinforcement**

Systematic positive reinforcement is a behavioral technique in which a psychotherapist encourages a client to reward positive or adaptive behaviors with something pleasant. This technique also works because it involves withholding a chosen reinforcement in response to maladaptive behavior.

**Homework**

Homework is an assignment or “mission” given to clients by psychotherapists to support progress between therapy sessions. Homework assignments might include reading or practicing coping skills learned in therapy (e.g., abdominal breathing).

**Flooding**

The process of flooding involves exposing people to fear-evoking stimuli intensely and rapidly. During flooding, clients are prevented from escaping or avoiding the feared stimulus.

**Modeling**

Modeling uses role-play to teach appropriate ways to respond to difficult situations. With this technique, the client uses the psychotherapist as a model to solve problems in her or his life.

**Therapeutic Process**

CBT is goal oriented and characterized by a highly collaborative relationship in which the psychotherapist and the client work together to identify maladaptive cognitions and behavior, test their validity, and make revisions where needed. A principal goal of this collaborative process is to help clients effectively define problems and gain skills in managing these problems in the future. As in other effective psychotherapies, CBT also relies on the nonspecific elements of the therapeutic relationship, such as rapport, genuineness, understanding, and empathy.

CBT for mental disorders such as uncomplicated depression or anxiety disorders can typically be completed in a range of 5 to 20 sessions. More complicated cases involving severe or chronic mental illness may require more than 20 sessions. “Booster sessions” are often used after therapy is completed to help limit the likelihood of relapse.
Coherence Therapy can also be implemented effectively in group settings, as with the skills training groups used
in DBT.

CBT sessions are structured to increase the efficiency of treatment. Sessions begin with a functional assessment leading to the establishment of realistic goals. Homework assignments are used to extend the client’s efforts beyond the confines of the psychotherapy context. Homework also helps structure therapy by serving as a recurrent agenda item that links one session with the next.

Psychoeducation is another key feature of CBT. Skilled psychotherapists who use CBT have extensive knowledge of readings and other educational aids specific to their area of expertise. Typically, clients are asked to read self-help books, pamphlets, or handouts during the beginning phases of therapy. Workbooks can also be used for specific problems. More recently, computer-assisted CBT tools are gaining popularity, as they offer opportunities for clients to better track their progress and practice skills interactively using technology.

Robert Rice

See also Beck, Aaron T.; Behavior Therapies: Overview; Cognitive-Behavioral Therapies: Overview; Ellis, Albert; Linehan, Marsha; Meichenbaum, Donald

Further Readings


Coherence Therapy

Coherence therapy is a focused, experiential methodology that guides deep resolution of the core emotional themes that maintain a client’s presenting problems and symptoms. Applicable with individuals, couples, and families, it is a systematic application of what is known about emotional learning and unlearning. The coherence therapy approach consists of bringing the implicit emotional learnings underlying and generating a given problem or symptom into explicit awareness and then guiding the innate process of memory reconsolidation to unlearn and dissolve that material. This process ends symptom production at its emotional and neural roots. Coherence therapy is a system of transformational change, as distinct from incremental change, and is applicable to all the acquired, unwanted patterns of behavior, mood, emotion, thought, and somatization arising from the persistence of implicit emotional learning and memory.

Historical Context

Developed initially from 1986 to 1994 by the psychotherapists Bruce Ecker and Laurel Hulley, the method was first known as depth-oriented brief therapy, the title of their 1995 book. Ecker and