

All in the mind: What is Cognitive Behavioural Therapy and how does it Work?

In this article Counselling Psychologist, **Antonietta DiCaccavo** gives an overview of Cognitive Behavioural Therapy and presents a case example to show what CBT might look like in practice with a client.

Cognitive Behavioural Therapy (CBT) is a fast growing and popular form of psychological therapy. After its original development in the US it has developed strongly in the UK. The National Institute of Health and Clinical Excellence (NICE) which issues guidance on mental health issues based on clinical research trials, advocates CBT as the preferred therapeutic choice for individuals presenting with depression and anxiety. Government funded initiatives such as Increasing Access to Psychological Therapies (IAPT) draw heavily on these guidelines and other economic arguments (e.g. Layard report, 2007) in its current drive to train increasing numbers of individuals as cognitive behavioural therapists. So what exactly is CBT and how does it work?

Inside the mind

Imagine turning up to a lecture one day where the tutor announces that she wants you to give a presentation to your fellow students on what you have learned on the course so far. Many people would immediately start to feel nervous at this prospect. You might feel your heart pounding, your palms sweating and you perhaps have the urge to run away from the situation. Now let's take a guess at what is possibly going through your mind. This might to some extent be out of your conscious awareness, but it is likely to be something like this; 'My presentation will be a disaster, I don't have anything interesting to say', 'I'll go red and shake, people will think I look stupid', 'I knew I shouldn't have started the course, I'm an idiot'. On the face of it, when you are in this situation you are likely to conclude that doing presentations in front of others' makes you nervous.

The power of thinking

However, there is another perspective on emotions that can challenge this conclusion in a helpful way. From a cognitive behavioural viewpoint, it is more accurate to conclude that it is not presentations themselves that are the problem, but instead the way that a person thinks about them. Moreover, because the way we think and feel affects our behaviour, a person using these kinds of negative descriptions is likely to behave in ways that confirm his

worst fears; this might be in form of clamming up, showing outward signs of anxiety and being unable to recall anything of the course so far.

When thinking about presenting in front of others, a person is likely to be making a number of what Aaron T. Beck, the originator of CBT, calls 'cognitive errors' (Beck, 1976). These are patterns of thinking that bias our interpretations of ourselves, others and the world in a negative way. These errors typically consist of extreme thinking that has a black and white, all or nothing quality. Specific examples are 'Catastrophising' or predicting the worst ("This will be as disaster"), 'Mind reading' or guessing what others might think ("People will think I look stupid"), 'Overgeneralising' (I knew I shouldn't have started the course") and 'Labelling' or attaching a highly emotional negative labels to the self ("I'm an idiot"). No wonder you feel anxious about doing that presentation!

Beck believed that distorted thinking was part of the human condition and therefore saw CBT as a therapy for all, not just those who had diagnosed mental health problems. Nevertheless, CBT is mainly used in therapy for depression and anxiety, with broadening applications that include personality disorders, eating disorders and psychosis (Freeman, Pretzer, Flemming & Simon, 2004). The aim of CBT is first to identify problematic ways of thinking and then to challenge them, establishing more realistic and therefore adaptive ways of responding and feeling. To this end, a person might be facilitated to appraise the situation of giving a presentation in an alternative way, it might go something like this; "Everyone will find this a bit of a challenge, I could talk about last week's session as I can still remember that pretty well", "I'm bound to be a bit nervous, no one has had time to prepare but we're in the same boat", "This is an opportunity to see what I am learning and to hear about other people's learning too". With this set of thoughts, there is still likely to be some element of nervousness. However, the person is less likely to be overwhelmed by anxiety and thus more likely to give an acceptable performance.

CBT in practice

The above scenario illustrates the central tenet of CBT, which is that it is not events per say that cause us distress, but the way we interpret and process the meaning of those events. In turn, the way that we then feel about events influences the kind of behaviour we exhibit. Much of the time, the kind of appraisals we make serve us well. For example, it is wise to interpret that driving carries some element of risk, which in turn motivates us to behave in appropriate ways, such as wearing our seat belts and obeying speed limits. However, problems would arise when potential dangers in driving are over exaggerated. Individually are not necessarily aware that their thinking is exaggerated or biased. So, the first step in therapy is to bring exaggerated thinking, (for example 'If I drive, I will be killed') into the client's conscious awareness. This is achieved in CBT through 'Socratic questioning' a series of curiosity driven questions, such as 'What was going through your mind when you got into

the car?' The therapist is interested in the feeling that these thoughts provoked and in turn how the client behaved in response to them, for example, a client might report, 'I felt too frightened and went back in the house'.

Once identified, cognitive errors are then up for challenge, again through the process of Socratic questioning, such as 'Can you think of times in the past when you did go out in the car and you were not harmed?' If a client answers 'yes' to this question, in CBT terms this raises doubt over the client's cognition, and through further challenges, the client is likely to see that getting killed does not logically follow from driving in the car. Behavioural tasks and experiments are also important ways for clients to challenge their thinking. So a client might gradually expose themselves to their fears, using more realistic thinking to work their way through a series of steps that include starting at the least challenging stage, such as sitting in their car on the driveway, to eventually being able to reach their end goal, which could be driving on the motorway.

Case example

Sue was referred by her GP to see a psychologist as she had become unable to drive due to overwhelming feelings of anxiety. This problem had begun following a car accident in which the car that Sue and her husband had been travelling in had been shunted from behind into oncoming traffic. Although neither was seriously injured, from that time onwards she described feeling so anxious when she saw a car in her rear view mirror that she had to pull over and call her husband to collect her. Over some months, Sue has found that just getting into the car became extremely anxiety provoking and she has been unable to move the car off the drive. Over a course of twelve sessions of CBT we identified the thoughts that Sue had when she got into her car. Largely they centred on the dangerousness of driving and included specific predictions, such as "If I go out in the car I will get killed this time, I won't get a second chance", "If I don't drive I can stay safe", "Any collision with another car will kill me". Over sessions, I facilitated Sue to challenge these assumptions. For example in 40 years of driving, Sue had only had this one accident which challenges the idea that driving necessarily equates to being killed. Sue was able to see that even if she gave up driving, life is still not without risk, which is an inevitable part of life. Even though the collision had been quite major, Sue and her husband had survived the accident so there is insufficient evidence to say that collision necessarily means fatality. At the same time as challenging her cognitions, over the weeks Sue embarked on graded exposure to her feared situation. This began by Sue first agreeing to sit at the wheel of her car daily for at least twenty minutes, progressing to moving the car on the drive way, driving around the block and eventually being able to do a stretch of motorway. A further aspect of the CBT was for Sue to learn some relaxation skills in order to cope with her anxiety while doing the graded exposure. In behavioural terms, the pairing of driving with a relaxed state also enabled Sue to learn that driving can be associated with a pleasant, comfortable state rather than a distressed fearful

one. By the end of our time together Sue was able to manage her driving anxiety by using relaxation techniques, challenging her problematic cognitions, and approaching rather than avoiding her fear by practising driving at least once a day.

Alternative models

CBT, originally developed in the 1970s, is a relative newcomer on the therapy scene, and it is not without its critics. One of the key criticisms aimed at CBT is its insufficient attention to the therapeutic relationship between client and therapist, the cornerstone of other therapies, such as psychodynamic and person-centred models. This is not helped by its emphasis on goal setting, structure and systematic conceptualisation, which is carried out in a time limited framework (often between 6-12 sessions). A further criticism is that CBT is not interested in the past, in that it pays relatively little attention to the very early life experience of the client. In this sense CBT can be portrayed as a rather cold and mechanical form of therapy, made up of a prescribed set of techniques that ignore the client's emotions and early life. However, by revisiting Beck's original conceptualisation of CBT and acknowledging more recent developments in CBT, such criticisms began to unravel (Sanders & Wills, 2008).

It is clear from Beck's writing that he saw warmth, acceptance and respect as essential to CBT. However while those therapists from a strictly 'relational' persuasion believed that the 'relationship is the therapy' (Kahn, 2001), Beck argues that although the relationship is necessary, it is not sufficient to bring about change. Moreover, Beck is more specific about how the relationship can be used, referring to this as 'collaborative empiricism', which enables the therapist to 'get alongside' the client with a 'two heads are better than one' approach to the client's difficulties (Beck, 1985). Recent developments in CBT have endeavoured to address concerns about the quality of the relationship and use of early experience in CBT. A more interpersonal focus to CBT (e.g. Safran & Muran, 2001) recognises that core schemas or ideas about the self (e.g., I am worthless, unlovable, defective') that are formed early on in life are encoded in highly emotional ways.

Conclusion

CBT seeks to understand the meaning of experiences for the individual, with a view to re-evaluating those meanings which are exaggerated or unhelpful. The popularity of CBT over recent years is hard to ignore and on the basis of research, it informs the kind of therapeutic input that clients are offered. Most Counselling and Clinical psychology Doctorate programmes train students to use CBT and this is the model that clients are most likely to experience in NHS settings. In a climate of recession where the need to 'make people feel better' as quickly, effectively and cheaply as possible, the challenge for CBT will be to hang

on to its philosophical principles and continue to value the collaborative relationship between client and CBT therapist;

'It is useful to conceive of the patient-therapist relationship as a joint effort. It is not the therapist's function to reform the patient: rather his role is working with the patient against the patient's problem'. (Beck, 1976)

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