Cognitive Behavioural Therapy Fundamentals

Deborah Dobson

Addictions Day

May 26th 2017

DISCLOSURE

I currently have no financial relationship with commercial enterprises & cannot identify any potential conflict of interest for the purposes of this presentation.

OVERVIEW

Cognitive behavioural therapy (CBT) has become one of the major models of evidence-based psychotherapy and is commonly used in all areas of addictions and mental health. This 75 minute introductory workshop will provide an overview of the model as well as some of the research support for its use. The fundamental building blocks of CBT will be presented in an accessible, engaging and practical way. Participants will be exposed to core skills through presentation, discussion and demonstration. Case examples will be utilized to promote audience participation.

TODAY, WE WILL:

- Learn to "think" like CBT practitioners in assessment and case conceptualization
- Learn to structure CBT—agenda setting, session structure and homework
- Learn to utilize behavioural experiments to challenge thoughts
- Learn fundamental CBT skills

OVERVIEW OF COGNITIVE BEHAVIOURAL APPROACHES

PRINCIPLES OF CBT

There are three basic propositions or principles that cut across all of the treatments in the cognitive behaviour therapy movement. (Dobson & Dozois, 2008). These principles include:

1. *The access hypothesis*, which states that the content and process of our thinking is knowable. Thoughts are not "unconscious" or "pre-conscious", or somehow unavailable to awareness. Rather, the cognitive behavioural approaches endorse the idea that, with appropriate training and attention, people can become aware of their own thinking;

PRINCIPLES OF CBT

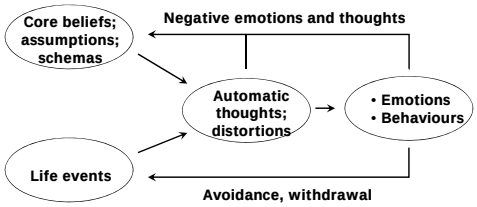
2. *The mediation hypothesis*, which states that our thoughts mediate our emotional responses. We do not simply have an emotional response to an event or situation, but rather how we think about the event is pivotal to the way that we feel. Consequently, thoughts mediate our feelings and influence our actions. For example, we will feel anxious only when we view a situation as threatening. These thoughts, as well as the corresponding emotional responses and behavioural reactions, may become "automatic" over time. Cognitive behavioural theorists argue that there is cognitive mediation between the event and the typical responses that the person has in that situation.

PRINCIPLES OF CBT

3. *The change hypothesis*, which is a corollary of the previous two ideas. It states that because cognitions are knowable, and because cognitions mediate the responses to different situations, we can intentionally modify the way that we respond to events around us. We can become more functional and adaptive people through understanding our emotional and behavioural reactions, as well as using cognitive strategies systematically.

CBT OVERVIEW

- CBT is based on the Cognitive Model of Emotional Response
- CBT is problem-focused and time-limited
- A sound therapeutic relationship is necessary for effective therapy, but not sufficient
- CBT involves a collaborative empirical approach between the therapist and the client
- CBT uses the Socratic Method, which refers to a style of questioning
- CBT is structured and flexibly directive



The cognitive therapy model of emotional distress.

CBT

- Widely used & widely researched.
- Has been used for many problems—depression, substance use and abuse, all types of anxiety disorders, personality disorders (DBT). Can be used in group (e.g., CBGT for social anxiety disorder), individual or couples therapy.
- Most CB therapies combine behavioural & cognitive components—generally the more dysfunctional the client, the greater the emphasis on behavioural techniques.

WHAT IS THE EVIDENCE FOR CBT?

		Type of efficacy data		
Disorder	Treatment	Absolute efficacy	Efficacy relative to medications	Efficacy relative to other psychotherapies
Specific phobia	Exposure and cognitive restructuring	++	+	
Social anxiety disorder	Exposure and cognitive restructuring	++	=	=
Panic disorder	Exposure and cognitive restructuring	++	=	+
Generalized anxiety disorder	Exposure and cognitive restructuring	+	=	+
Posttraumatic stress disorder	Exposure and cognitive restructuring	++	+	=
Obsessive–compulsive disorder	Exposure and response prevention	++	=	+

Note. A blank space indicates insufficient evidence to form a conclusion; + indicates positive evidence; = indicates approximate equivalence; ++ indicates treatment of choice.

* Cognitive- behavioral therapy is used typically as an adjunct to medication in these disorders.

- Source—Dobson & Dobson (2017)

		Type of efficacy data		
Disorder	Treatment	Absolute efficacy	Efficacy relative to medications	Efficacy relative to other psychotherapies
Hoarding Disorder	Cognitive restructuring, item removal, affect regulation	+		
Major Depressive Disorder	Activity, cognitive restructuring, and schema change	+	+	=
Bipolar disorder*	Affect regulation and cognitive restructuring	+		+
Substance- related and addictive disorders	Affect regulation, behavioral control, and cognitive restructuring	+	+	=
Eating Disorders	Eating regulation and cognitive restructuring	+	=	+

Note. A blank space indicates insufficient evidence to form a conclusion; + indicates positive evidence; = indicates approximate equivalence; ++ indicates treatment of choice.

* Cognitive- behavioral therapy is used typically as an adjunct to medication in these disorders.

- Source—Dobson & Dobson (2017)

		Type of efficacy data		
Disorder	Treatment	Absolute efficacy	Efficacy relative to medications	Efficacy relative to other psychotherapies
Sleep disorders	Behavioral control and cognitive restructuring	++	+	+
Chronic fatigue syndrome	Activity scheduling; cognitive restructuring	++	+	+
Anger and aggression	Cognitive restructuring; emotional control	+		=
Psychosis*	Affect regulation and cognitive restructuring	+		+
Somatic Symptom Disorders	Distress tolerance and cognitive restructuring	+	=	
Irritable Bowel Syndrome	Distress tolerance and cognitive restructuring	+	=	
Borderline Personality Disorder	Dialectical behavior therapy	+		

Note. A blank space indicates insufficient evidence to form a conclusion; + indicates positive evidence; = indicates approximate equivalence; ++ indicates treatment of choice.

* Cognitive- behavioral therapy is used typically as an adjunct to medication in these disorders.

- Source—Dobson & Dobson (2017)

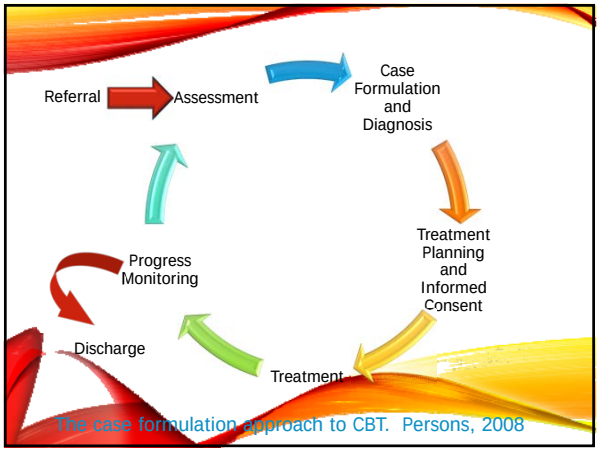
PRINCIPLES OF CBT

1. Need for cognitive case formulation
2. Based upon sound therapeutic alliance
3. Emphasizes collaboration and active participation from client
4. The therapy is goal oriented and problem-focused
5. Emphasizes the present (at least initially)
6. The therapy is educative
7. The therapy encourages relapse prevention
8. The therapy is time-limited
9. Sessions are structured
10. The therapy uses a variety of techniques to change thinking, behaviour and mood.

Source: J. Beck, 2011

THE TYPICAL PROCESS OF CBT

1. Intake assessment (diagnosis, severity, suicide potential, functional assessment)
2. Case formulation
3. Education about the model
4. Behavioural skills (e.g., activation/reduction of avoidance)
5. Cognitive restructuring
6. Modifying underlying beliefs, schemas
7. Review, relapse prevention, and discharge planning



The case formulation approach to CBT. Persons, 2008

MAJOR TREATMENT COMPONENTS

- General psychotherapy issues
- Information and education
- Behavioural experiments
- Exposure to phobic stimuli
  - Imaginal, interoceptive, in vivo
- Managing avoidance/ “safety behaviours”
- Skills training
- Cognitive restructuring
- Relapse prevention & ending therapy

SETTING TREATMENT GOALS

1. Be collaborative and work with the client to formulate goals which can lead to possible interventions. Goals should be agreed upon by client and therapist.
2. If possible, set an early goal that is likely to lead to quick success or a reduction in distress.
3. Goals can focus on reducing symptoms and problems.
4. Focus on increasing desired behaviours or outcomes.
5. Goals should be emotionally compelling to the client.
6. When setting goals, it is important to establish ways to assess outcome.
7. Goals should be prioritized.

SETTING TREATMENT GOALS

8. Goals can be divided into affective, behavioural, cognitive, interpersonal and environmental.
9. Goals can also be categorized into immediate (e.g., within the session), short-term, medium-term and long-term.
10. Some clients find it helpful to use the SMART acronym:
    - S = specific
    - M = measurable
    - A = achievable
    - R = relevant and realistic
    - T = time-limited

INFORMATION & EDUCATION

- Very useful initial step--provides a good basis for collaboration
- Important to match information to the client—be aware of education level, literacy, comfort with different types of materials
- Can be accomplished in a variety of ways--verbal, written, video, web-sites, support-groups, TED talks.

STRUCTURING CBT

- The therapy should be structured from the beginning in terms of frequency of sessions, length of sessions, content and process of sessions;
- Verbal and written treatment contracts are frequently used;
- Outcomes should be assessed at regular intervals;
- Balance between structure and flexibility;
- Each session for CBT has a typical structure.

STRUCTURING CBT SESSIONS

The typical format for a CBT session includes:

1. A general check-in, including a mood or distress rating, and a comment about, or "bridge" from the previous session;
2. A brief review of homework that was assigned, attempted and completed;
3. A discussion of any pressing issues for the current session;
4. Agenda setting, including priority setting and approximate time allocated for each topic;
5. Discussion and work on each agenda item;
6. Summary of the session's main points;
7. Feedback about the session;
8. Discussion of the overall homework, including anticipation of problems, practice regarding any concerns, and final homework assignment.
9. 10-30-10 Guideline

Homework

WHY IS HOMEWORK IMPORTANT?

- Term can vary from “self-help” assignments, “between-session” assignments”, “home-practice” activities, experiments, etc....
- Some clients have a negative reaction to the term “homework”, with connotations of school or being evaluated.
- The purpose is to foster learning, create opportunities for change outside of the session, increase client’s observation and understanding.
- Most psychotherapies use homework (formally or informally)—in CBT, the homework is typically collaborative, explicit and formal.
- Major purpose is to increase generalization of change from inside therapy session to outside therapy (to the client’s life).

SUCCESS WITH HOMEWORK

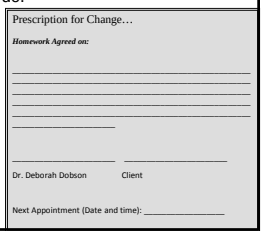
1. Ensure that decisions regarding homework are collaborative rather than decided upon by the therapist or client alone.
2. Leave sufficient time at the end of each session to discuss and develop homework assignments.
3. Ensure that there is a mutual understanding regarding the assignment—it can be helpful to have the client paraphrase what their understanding of the homework is.
4. Provide a good rationale for the homework so that it is clear how this particular assignment is related to the overall treatment goals.

SUCCESS WITH HOMEWORK

5. Obtain a commitment on the client’s part to complete the homework.
6. The assignment should be specific and clear rather than general (e.g., “practice eye contact with 3 different people per day” compared to “practice nonverbal social skills”).
7. Evaluate success by client’s efforts and homework process rather than outcomes, which is consistent with collaborative empiricism. (e.g., if the client practiced eye contact as above, it was successful independently of whether or not the other people responded positively).

SUCCESS WITH HOMEWORK

8. Ensure that the client has both the resources (e.g., financial, emotional, motivation) and skill (e.g., literacy, social, knowledge) to complete the homework.
9. Use memory aids, such as homework sheets or the *Prescription for Change*. Clients may be anxious in session and have good intentions to complete their homework, but may genuinely forget exactly what it was they were to do.



Prescription for Change…

Homework Agreed on:

_____
_____
_____
_____
_____
_____

_____ _____

Dr. Deborah Dobson Client

Next Appointment (Date and time): _____

SUCCESS WITH HOMEWORK

10. Have the client predict the likelihood of that they will complete the homework. If it is less than approximately 70%, consider changing or simplifying it or finding a strategy that will increase the chances.
11. Ensure that you ask about the homework during the following session and verbally reinforce homework efforts and completion.
12. Consider assigning yourself homework in order to model homework completion. Your homework may include accessing psychoeducational material or finding out information relevant to a client's problems.

A FEW OTHER POINTS ABOUT HOMEWORK

- Ensure collaboration
- Provide a solid rationale
- Be clear and explicit
- Ask about obstacles
- Ask for client automatic thoughts in session
- Role play procrastination or negative thoughts
- Start the assignment in session, if possible

BEHAVIOURAL EXPERIMENTS

There are many different kinds of behavioural intervention, however, the purpose of *behavioural experiments* is to shift thinking, not to teach skills.

In practice, experiments are quite similar to exposure therapy, but the explicit purpose is somewhat different.

- First step is to identify a prediction, negative or problematic thought with your client;
- Second step is to help the client see this thought as "testable" with an experiment (collaborative empiricism);;
- Third step is to figure out some possible ways to test the hypothesis;
- Next step is for the client (and/or you) to gather information/data and bring it back to the next session;
- This data collection may involve the client doing something differently;
- The data "analysis" takes place within the next session—the client's thought can then be re-assessed;
- The process of changing thoughts occurs during the "test" and is reinforced within the session.

Let's think of possible experiments for these clients:

- Client engages in "pre-drinking" before going out with friends and expresses a belief that they are boring and uninteresting to others;
- Client has a history of panic attacks and uses marijuana to cope. Their panic attacks appear to be reduced over what they were in the past;
- Client has been using greater amounts of sleeping pills, but reports that their sleep is still disrupted;
- Client is excessively focused upon cleanliness and reports that they wash their hands at least 25 times per day;
- Client reports that people respond only when they are loud and demanding.

For each of these clients, what additional information could you ask about? What information could they gather? What behavioural experiment could they conduct between sessions?

EXPOSURE THERAPY

- The single most effective behavioural strategy
- Minimize avoidance—encourage courage
- Gradually reduces anxiety and helps shift beliefs—can't say that you are unable to do something if you are actually doing it!

WHEN WE AVOID

- Initially decreases anxiety … feel relief
- Never learn that situation is not dangerous
- Anxiety tends to grow
  - Often we monitor physical reactions as they become a sign of danger … if we monitor our physical reactions they disregulate and increase
  - Increasing number of situations become signals of danger

SAFETY BEHAVIOURS

SAFETY BEHAVIOURS

- Safety behaviours are ways in which clients minimize the effectiveness of exposure or experiments. These are ways, often automatic that the client uses to minimize their anxiety and to cope. Examples of safety behaviours vary from client to client, problem to problem. They can include behaviours or cognitions, any of which can be anticipatory, during the session or after the session. As these are quite automatic & the client thinks of them as helpful, they can be difficult to identify & reduce. These are probably crucial to change, as the likelihood of change is reduced if they are not.

EXAMPLES OF SAFETY BEHAVIOURS OR MAINTAINING FACTORS

- Use of alcohol or drugs (prescribed or unprescribed);
- External or internal avoidance (internal e.g., daydreaming);
- Sitting near exits, knowing where all exits, bathrooms are;
- Avoiding eye contact or talking, wearing very plain clothes to avoid attention;
- Going only to “safe” places;
- Telling self that de-contamination can take place after exposure session;
- Telling self that therapist’s materials for exposure are “safe” or “cleaner than average”, so risk is minimized.

THE COGNITIVE SIDE OF CBT

Emotions are viewed as the physical (bodily) consequences of our thoughts.

Imagine the following situation: You are scheduled to go for dinner with a friend, followed by a hockey game. Your friend has the tickets. They were to pick you up at 5:30 p.m. It is now past 6:00, and there's been no sign of her — not even a phone call. How are you going to feel about this? What are your thoughts? What do you do?

Many automatic thoughts (especially for anxious clients) come in the form of questions.

- Automatic thoughts are thoughts that come to mind involuntarily and without effort;
- Most of our thoughts are automatic — they just happen, without being planned or intended;
- ATs may be accurate or distorted.
- Their effects may be beneficial, harmful or neutral;
- CBT helps clients learn to recognize and deal with unhelpful thinking.

COGNITIVE RESTRUCTURING

- What is the evidence?
- How would someone else react?
- What standards are being set?
- Is there emotional reasoning?
- What is the worst case?/ best case? Realistic probability?
- What is the long term effect?
- How much control really exists?
- **The three questions:**
  - **1. What is the evidence?**
  - **2. What are the alternatives?**
  - **3. So what?**

COGNITIVE RESTRUCTURING

- What are the facts?
- What do you know for sure?
- Would this evidence stand up in a court of law?
- What would a judge say about your evidence?
- Have the questions answer their own questions!

Bottom line—most thoughts are just your opinion!

HEALTH CARE CUTS?

RELAPSE PREVENTION & ENDING THERAPY

- Review goals of therapy
- Review skills learned & changes made in therapy
- Encourage practice and generalization
- Set future goals & orientation towards possible setbacks
- Trouble-shoot possible problems
- Discuss feelings about ending therapy
- Summary and feedback

COMMON ISSUES IN TREATMENT

A few key suggestions:

1. Be focused & plan successes with your clients—it's better to have success with one small area than failure with a big problem;
2. Be specific & concrete;
3. Avoid "why?" or "meaning of life" kinds of questions—ask how, not why;
4. Remember than "motivation follows action";
5. "Encourage courage";
6. Keep asking "What are the facts?";
7. Reinforce any efforts & small changes (be specific & genuine);
8. Write down homework & always remember to ask about it next time. Be supportive but persistent!

WHAT ARE THREE SKILLS TO WORK ON IN YOUR PRACTICE NEXT WEEK?

Contact me: drdebdobson@shaw.ca
www.drdebdobson.ca


THANK YOU!