Cognitive behavioural therapy: theory and applications

Cognitive Behavioural Therapy Assessment

IntroductionDefinition of Cognitive behavioural Therapy

The term Cognitive behavioural therapy (CBT) covers a number of techniques of spoken interactive therapy which are considered useful in helping people solve life problems such as anxiety, depression, post-traumatic stress disorder (PTSD) and various addictive problems. (Beck A T 2005)

Basic theoretical principles

Cognitive behavioural therapy has arisen as a hybrid therapy combining the elements of cognitive therapy, which was originally conceived and developed to assist in changing dysfunctional beliefs, thoughts, attitudes, and expectations, and behavioural therapy (which is referred to as behaviourism) – which was originally developed to change how people acted in response to various stimuli.

Influential authorities such as Beck suggested that how one thinks about a situation determines how one acts and our actions determine how one thinks and feels. (Beck A T et al. 1979). This therapy endeavours to change elements of thinking (cognition) and behaviour together in order to achieve its beneficial effect on feelings.

The therapy is based on an assumption that feelings and behaviour patterns such as anxiety and avoidance behaviours are related to the development of maladaptive beliefs and their related thought processes in an individual. Therapy is based on a series of collaborative interactions between the

patient and the therapist in conjunction with specific cognitive and behavioural techniques such as Socratic dialogue, monitoring of beliefs, activity monitoring and scheduling, analysing advantages and disadvantages of avoidance, graded exposure assignments, behavioural experiments and role-play. The exact form of the therapy will depend on the presentation of the patient and the professional expertise of the therapist. (Hobbis I C A et al. 2005)

Brief overview of the evidence base to support CBT

There are two basic issues here. In order to define the evidence base for Cognitive behavioural therapy, one has to define the condition for which it is said to be efficacious. In the context of this essay, one can specifically consider Cognitive behavioural therapy in the area of anxiety treatment. A good place to start is the study by Stanley (Stanley M A et al. 2003). This was a small retrospective study which Cognitive behavioural therapy was contrasted with “ usual care” and demonstrated a clear statistically significant advantage in the Cognitive behavioural therapy group on a broad battery of anxiety measurement tools. This correlates well with other findings from larger studies (viz Wetherell J L et al. 2005) and the meta analysis by Pinquart (Pinquart M et al. 2007)

Principles and practices of CBT assessment

Role and purpose of CBT assessment process related to relevant theory described previously.

Describe the different stages of CBT assessment process.

There are a number of different assessment models. For an illustrative example one can use the Williams Garland model (Williams C et al. 2002). This model uses five discrete areas of assessment which are described as:-

Area 1: Situation, relationships and practical problems For example, Debts, housing or other difficulties. Patients may have problems in relationships with family, friends, colleagues, etc. Life events such as deaths, redundancy, divorce, court appearances may all be relevant.

Area 2: Altered thinking

An exploration of the typical characteristics of dysfunctional thinking that are commonly found in anxiety and depressive states, for example patients may display an ability to overlook their strengths and become very self-critical. Patients will often unhelpfully dwell on past, current or future problems; they put a negative slant on things, using a negative mental filter that focuses only on their difficulties and failures. They can catastrophise events and will typically mind-read and second-guess that others think badly of them, rarely checking whether this is true. (after Whitfield G et al. 2003)

Area 3: Altered emotions There are a number of altered emotional states commonly found in anxiety states which can include feelings of anxiety, stress, worry, fear, panic and being ‘ hassled’. Guilt, anger and irritability are common as are shame and embarrassment.

Area 4: Altered physical symptoms

There is a wide variety of symptoms commonly found in anxiety related conditions and these can include restlessness and an inability to relax,

feeling of tension, shakiness or unsteadiness when standing, insomnia, palpitations and feelings of depersonalisation.

Area 5: Altered behaviour

In anxiety states one of the commonest symptoms is avoidance behaviour which can usually be elicited by asking the question ‘ What things have you stopped doing since you started feeling anxious?’

Define and describe role and purpose of formulation in CBT assessment

There are two major reasons for this type of assessment. Firstly it serves as a guide for the practitioner to determine the impact of the anxiety (or depression) on the patient’s overall subjective experience and thereby define goals and targets. Secondly it is helpful for the patient. The Five areas assessment model is easily grasped and understood by patients and thereby allows for an understanding of the effects that their anxiety state has on them. Often the act of writing down their symptoms under the headings allows for a degree of emotional distance which allows a patient the ability to examine their symptoms more objectively.

Discuss the role and purpose of measurement in CBT model including psychometric and ideographic measures and problem and target statements

Include relevant references and appendices (e. g. examples of measures)

The academic determination of the evidence base for Cognitive behavioural therapy is ultimately based on studies that have measured the degree of response to the intervention. To this end there are a number of tools

available for measurement. A comparatively new tool that has been described in the literature is the Questionnaire on Control Expectancies in Psychotherapy, (Jennings S 2008) which quantifies the degree to which responsibility for change is shared between therapist and patient. Other older tools include the state trait anxiety inventory, the graphic anxiety scale, the hospital anxiety and depression scale, and the anxiety-defining characteristics tool (Chuldham C M et al. 2008)

Engagement issues

Engagement with the patient can be a complex matter. A brief overview of the literature on the subject suggests that studies that have shown a poor patient response to Cognitive behavioural therapy have identified one of the causes to be inadequate expectancies of the patient specifically regarding the responsibility and the mechanisms of therapeutic change. Responsibility can be assigned to the therapist rather than the patient. In this respect, assessing control beliefs specific to the context of the psychotheraputic approach and specifically linking them to the expected therapy outcome can help highlight this specific aspect.

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