

How effective is
cognitive behavioural
therapy?



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Introduction

Individuals respond to stressful events in different ways and their responses are influenced by a number of factors, such as personality characteristics or temperament, that can have an effect on the how the stressor is perceived (Anthony, Frederici, and Stein, 2009). Anxiety and stress are closely related, although stress tends to relate to a specific event or circumstances, whereas anxiety can be a non-specific, internal anticipation of something that might happen (Kahn, 2006). However, anxiety can cause stress – for example, imagining the consequences of being late (anticipation). Anxiety disorders are very common and can be debilitating and chronic, with patients experiencing distress over many years. It is suggested that anxiety is multifaceted and may be caused by biological factors – for example, high levels of serotonin, which is also a factor in depression. Another contributing cause to anxiety appears to be hyperactivity in the amygdala region of the brain, which results in high levels of neuroticism and anxiety. People who have a tendency towards neuroticism, for example, are more likely to experience anxiety disorders and negative emotions in response to stressors (Eysenck, 1967; Gray 1982). Psychological treatments and interventions focus on cognitive processes and behavioural responses that attempt to explain the acquisition and continuation of anxiety disorders (Anthony, et al. 2009). The aim of the following essay is to examine the efficacy of CBT interventions on treating anxiety and stress-related disorders.

Anxiety Disorders

The Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-V) classifies anxiety disorders into three main groups: anxiety disorders,

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obsessive compulsive disorders (OCD), and trauma and stress related disorders (American Psychiatric Association, APA, 2013). Anxiety disorders include separation anxiety disorder, phobias, social phobia, panic disorder, agoraphobia, and generalised anxiety disorder. Obsessive-compulsive disorders includes hoarding disorder, while the third group, trauma and stressor-related disorders, includes post-traumatic stress disorder (PTSD) and acute stress disorder (DSM-V, APA, 2013). The DSM-V classifications of anxiety emphasise the relationship between disorders and therefore the possibility of comorbidity between anxiety, stress and depression (APA, 2013).

Cognitive Behavioural Therapy (CBT)

As will be discussed in the following section, many of the stress and anxiety related conditions listed in the DSM-V category of anxiety disorders can be treated using cognitive behaviour therapy (CBT).

CBT aims to change negative and maladaptive thought patterns and behaviours to more positive ways of dealing with stress-related problems. Therapy is non-directive and a therapist will facilitate change through working with the client or patient to achieve a series of goals. The therapist will also challenge the client's negative beliefs and help the client develop strategies to manage their stress more effectively in the long term in order to prevent any relapses (Beck, 2011). Exposure-based CBT (Torp et al. 2015) has also been reported to be effective with young people and children. As discussed by Beck (2011) the relationship between the therapist and the patient is central to the success of the intervention, as it is necessary to have a rapport in order to sometimes discuss difficult topics.

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The Efficacy of CBT in Stress-Related Disorders

In their meta-analyses of 269 studies that used CBT in studies, including anxiety disorders and general stress, Hoffman, Asnaani, Vonk, Sawyer and Fang (2012) found that the most effective results were for anxiety disorders and general stress (together with bulimia, somatoform disorders and anger control). A study comparing 65 patients with generalised anxiety disorder (GAD), who were randomly allocated to one of three groups - CBT, relaxation techniques, and a control group of patients on the waiting list - was undertaken by Dugas et al. (2010). The follow-up sessions took place 6-, 12- and 24-months after the intervention and consisted of self-report and clinician ratings. It was found that both CBT and relaxation were more effective than the control group, although long-term improvement continued only with CBT (Dugas et al. 2010).

Other research has also found that CBT has been effective in generalised anxiety - for example, Otte (2011) states that a number of studies have demonstrated that CBT is effective for patients with anxiety conditions and states 'the efficacy and effectiveness of CBT in anxiety in adults appears to be well established' (Otte, 2011, p. 418). However, despite the positive findings, Otto also states that there are various methodological problems in many studies, for example studies that do not include a control group, and therefore the effect size of the intervention is more difficult to assess. CBT has also been found to be effective in anxiety disorders in children, although as Hogendoorn et al. (2014) reports there are children who do not respond and therefore greater research is necessary in order to understand the mechanism that allows some children to respond well, while other

children do not. In a study that investigated childhood anxiety and depression using CBT intervention it was found that there were more positive effects for anxiety than for depression in terms of behaviour and coping strategies used by the children (Chu and Harrison, 2007). It was concluded that there are different factors involved when using CBT in the treatment of anxiety and/or depression.

According to Leichsenring et al. (2013) social anxiety is a prevalent disorder that can cause severe psychosocial problems and can co-exist with other disorders such as depression. Social anxiety is characterised by an individual having a fear of social interactions and therefore affects a person's ability to work and have a good quality of life (Yoshinaga et al. 2013). There have been a number of reports regarding the efficacy of CBT in treating social anxiety, although many studies have small sample sizes and are conducted in one location. In their study Leichsenring et al. (2013) assessed 495 outpatients who were randomly allocated to either CBT intervention, (n= 209), psychodynamic therapy (n= 207), or a waitlist control group (n= 79). The patient's baseline and post-treatment scores were compared using the Liebowitz Social Anxiety Scale (Liebowitz, 1987). It was found that both CBT and psychodynamic therapy were effective in treating social anxiety.

Yoshinaga et al. (2013) also evaluated CBT and social anxiety in Japan using the Liebowitz Social Anxiety Scale (Liebowitz, 1987). The aim of the study was to assess whether results in Japan would be similar to those in Western countries. The intervention was over a 14 week period and measurements of social anxiety were taken before during and after the intervention. It was found that CBT was effective although there were a number of limitations in

the study. The sample size was very small, with only 15 patients, which limits the generalisability of the study to other patients, particularly as it was a single-centre study. Another limitation was that the participants were mainly females, which again can limit generalisability of the findings to male patients. There was also no long-term follow-up, so the effects of CBT in preventing relapse were not assessed. Furthermore many patients were also taking medication which was not controlled for and may have had an effect on the results.

Another stress-related condition which can cause serious impairment is OCD. The condition in adolescents and children is similar to that of adults, and OCD often begins in childhood (Torp et al. 2015). In a study undertaken in Denmark, Sweden and Norway, patients aged between 7- and 17-years diagnosed with OCD received CBT intervention in a community setting over 14 weeks. The study was an uncontrolled trial, which meant all patients received exposure CBT and were assessed using the Children Yale-Brown Obsessive Compulsive Scale (Scahill, et al. 1997), which both children and their parents completed, as well as other measures. The children had a range of behavioural and emotional problems and the study involved therapists and health professionals who evaluated the intervention. A strength of the study was that it was undertaken in different centres in three countries, which means it has good generalisability. The number of participants was also relatively high, which was also a strength of the study. The professionals helped the children and their parents complete the treatment and the findings showed a high success rate which was rated independently. It was concluded by Torp et al. (2015) that exposure-based

CBT is an effective treatment for OCD in community children and adolescent outpatient clinics. The severity of the symptoms decreased in the patients and some were described as being in remission. However, there were a few limitations in the study – for example, the group was not ethnically diverse and the trials were not randomised (Torp et al. 2015).

A final area where CBT has been found to be effective in stress-related disorders is PTSD, which is a disorder which can occur after an individual has experienced a major traumatic event. Typical symptoms include re-living the event, recurring thought of the event, avoidance, numbing and detachment and estrangement from family and other people. In looking at the efficacy of CBT in treating PTSD, Bisson and Andrew (2007) undertook a systematic review of research in which patients had been evaluated by clinicians for traumatic stress symptoms as well as self-rating by the patient of stress, anxiety and depression. Treatment included Trauma focused CBT (TFCBT), exposure therapy, stress management which included hypnotherapy and group CBT and eye movement desensitisation and reprocessing (EMDR) and a waitlist control group with no intervention. The findings showed that TFCBT, EMDR and group CBT were all effective in treating PTSD. In the long-term TFCBT and EMDR were found to be more effective, although some of the studies were found to have methodological flaws which means the data must be interpreted with caution.

After the attack on the Twin Towers in New York, the CATS consortium was established to help deal with the trauma experienced by young people and also to assess the outcomes of the intervention using CBT. The CATS Consortium (2010) report on the efficacy of CBT being used with children and <https://assignbuster.com/how-effective-is-cognitive-behavioural-therapy/>

adolescents aged between 5- and 21-years who were traumatised after the attack. The young people (n= 306) were allocated to one of two groups depending on the severity of their trauma. The first group involved trauma-specific CBT and the second group, brief CBT. The findings showed that for both groups there was a decrease in their symptoms and they were no longer diagnosed as having PTSD, and it was also found that the therapy could be effectively delivered in the community by trained professionals. The limitations of the study were that the design did not conform to a typical randomised controlled study and a control group was not used. The circumstances around the study were chaotic in the days after the attack and, as the authors state, the children may have improved without any treatment or intervention, which is, of course, the purpose of a controlled group. Nonetheless, the study has provided useful information regarding the use of CBT for young people after a traumatic event.

Conclusion

Overall, the evidence presented demonstrates that CBT is an effective intervention in a number of different stress-related conditions identified by the DSM-V (APA, 2013). Meta-analyses and systematic reviews are able to provide robust evidence regarding the effectiveness of interventions using CBT, although, as has been discussed, there are a number of methodological issues with some of the studies used in meta-analyses. Some of the limitations include small sample sizes, for example, which means that generalisation to other groups is not possible. Another limitation is the lack of a control group, where, as discussed by CATS Consortium (2010), the patients who were traumatised after the attack on the Twin Towers in New

York may have recovered spontaneously over time without any intervention, and this can only be observed in a control group which has no intervention. Another potential issue is the use of different measures such as self-report and clinician's measures (Dugas et al. 2010), in comparison to other studies which used validated questionnaires such as Liebowitz Social Anxiety Scale (Leichsenring et al. 2013). This means that comparisons between studies are more difficult. However research using CBT has taken place in a number of different contexts and cultures – for example, Norway, Sweden and Denmark (Torp et al. 2015) and also Japan (Yoshinaga, et al. 2013) – and has been shown to be effective.

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