Cognative behavioral therapy and two schools of psychology

Epictetus a Greek Stoic philosopher said, " Men are disturbed, not by things, but by the principles and notions which they form concerning things." In other words, behaviors and feelings are affected by how people think i. e. cognition. This forms the basic premise of Cognitive behavioural therapy which is viewed as a " psychological treatment of thoughts."

Cognitive Behavioral Therapy (CBT) is influenced by two schools of psychology: behavioral and cognitive therapy. According to Westbrook (2008) behavior therapy occurred as a rejoinder against the Freudian psychodynamic paradigm that had subjugated psychotherapy from the nineteenth century onwards. The theory was underlying classical conditioning which was based on Pavlov (Pavlov, 1927) work and operant conditioning based on Skinners (Skinner, 1938) Classical conditioning, which incorporates a naturally occurring or a conditional stimulus which has not previously formed a particular response becomes allied with an unconditional stimulus which produces the response. This result in the conditioned stimulus will obtain the response that the unconditional stimulus produces (psychologyandsociety. com). Operant conditioning is a process of learning which transpire through rewards and punishment for behavior (Wagner). Skinner believed that motivations and interior thoughts could not be used to elucidate behavior. Instead, Skinner suggested, individuals should look only at the external, recognizable causes of human behavior (Wagner). However, in America during the 1950s and early 1960s Aaron Beck a medical doctor, psychoanalyst and a psychiatrist saw that his patients were not going to improve with analysis (Webber, 2008). Both Beck and Albert Ellias noticed that patients were held back due to negative thoughts (Webber, 2008).

There was a great impact in psychology when Beck published his book on cognitive therapy for depression (Beck et al., 1976). In addition, research showed that CT was as effectual of a treatment for depression as anti-depressant medication (Rush et al., 1977). This was because CT helps individuals overcome obscurity by identifying and changing dysfunctional thinking which leads to an emotional reaction which results in a certain behavior. Cognitive therapy helps individuals to develop skills for modifying beliefs, identifying distorted thinking and changing behaviors (Beck, 2008). Over years, cognitive behavioral therapy and behavioral therapy grew and influenced to the amalgamation know as cognitive behavioral therapy.

The essential principles of CBT is that what people think influence how they feel physically and emotionally resulting in the alteration in what they do (Williams et al., 2002). Cognitive Therapy was pioneered by Aaron Beck, M. D. for the treatment of depression. Beck and other researchers have developed methods for applying cognitive therapy to other psychiatric problems, such as panic, anger control problems and substance abuse. This form of therapy has received considerable research support, especially with regard to depression.

The National Institute for Clinical Excellence (date), has stated the CBT uses techniques from behavioral therapy and cognitive therapy. Kinsella (2008) mentions that CBT is evidence based treatment that aspires to address patients' existing problems and the therapeutic sessions are highly structured. This treatment is goal oriented where goals are agreed between the therapist and patient in terms of improving the patient's difficult emotional states and unhelpful prototype of behavior and thinking. CBT is a

comparatively short-term (average 12-18 sessions) brief therapy which can be used for a wide range of psychological disorders such as: anxiety, depression, substance abuse, personality disorder and anorexia nervosa amongst others. Depending on the individual's needs CBT delivery varies: nevertheless, the main goal of CBT is to focus on working on the ' incorrect beliefs' that people have; these beliefs are usually involuntary however they critically affect how people respond to situations (virtual medical centre).

According to Westbrook, (2008) cognition mediates the emotional responses and behaviors. In other words, an individual's belief, thoughts, interpretations about themselves or the situation in which they find themselves essentially structure the meaning they give to the events of their live. To illustrate this point further in everyday life, if we were to ask individuals what makes them happy, angry, sad etc. often the answer would be a situation or accounts of events. For example " I am fed up because I have had a quarrel with my boyfriend." If an experience automatically gave rise to an emotion in such uncomplicated way, then it would follow that all individuals with the same situation would feel the same emotion. However, this is not the case- individuals react to a lesser or greater degree, individuals react in a different way to similar events; therefore it is something else which determines the emotions. The ' C' in CBT is the ' something else' is cognition, by way of explanation the interpretations people make of the event. The idiosyncrasies of an individual influences the manner in which a person reacts to an event so that, one person's reaction may seem idiosyncratic to another. This is due to the fact that each person has behavior patterns typical to him or her. The ' B' in CBT still uses part of

the legacy from Behavioral therapy however in CBT behavior reflects on what we do is a central part in changing the emotional state or maintaining the individual. CBT demonstrates that behavior has a strong impact on thoughts and emotions. Therefore, any kind of behavior, rules the way you think and react.

Cognitive therapy focuses on change at all levels cognition; negative automatic thoughts (NATs), dysfunctional assumptions (DA) and core beliefs. The term negative automatic thought is self explanatory and occurs without the realization of the person. To identify them one requires a concerted effort. According to Kinsella (2008), NATs present themselves through specific events and situations though they may vary in intensity. However, People can be conscious of NATs in their persona or notice their existence by monitoring them. Nevertheless, they are also so ingrained in a person that they may or may not be noticed at all. NATs emanate from the essence of one's beliefs and manner of living, representing daily experiences. In addition, they influence a person's mood constantly and have a central role to play in CBT. NATs are so part of an individual's existence that to view them objectively is a feat. The harsh reality is that NATs are always going to be part of human nature and temperament, so it is up to every individual to control them whenever they surface.

Dysfunctional assumptions (DA) or intermediate beliefs bridge the gap between NATs and core beliefs. According to Westbrook (2008), in nature, DA represents guidelines for living, being more specific in application than Core Beliefs but more general than NATs. The reason they are dysfunctional is because of their rigidity and this leads to hindrances while coping with

setbacks and complications in life. DAs are sometimes not easy to detect as they are inferential in nature. Nevertheless, they are approved of by some cultures and re-enforce attitudes like success. DAs are made of attitudes, rules and assumptions, symbolized as ABC by therapists (Ellias, 1962, 1977). " A" stands for activating an event; " B" stands for belief and " C" stands for consequence. DAs are introduced towards the latter half of therapy after people have learnt to cope with NATs. Modifying DAs may also prevent people from facing psychological problems repeatedly (Westbrook, 2007)

According to Grant 2004, core beliefs are also referred to as schemas or schemata. They signify the fundamental view we have about people, our world and ourselves. These beliefs appear early in life when we learn our first and lasting lessons. Core beliefs are, in essence, our realities. Therefore, they are not as readily alterable as automatic thoughts (which are the products of core beliefs). Longer-term cognitive therapy will focus a great deal on core beliefs. Nevertheless, core Beliefs encompass domains related to self, basically negative aspects of self- like failure, the unfairness in the world and inferiority complexes (Kinsella, 2008). People find it difficult to distance themselves form core beliefs and tend to define themselves based on their content. Lately, therapists have devoted much time to core beliefs and have shown how they play a vital role in maintenance of varied long time psychiatric problems (Kinsella, 2008).

The key principles of Cognitive behavioural therapy that has been adopted from Beck, 1976; Beck et al., 1985 and Beck, J. 1995 are broken into four categories.

First, a base from which to help patients: CBT requires a good therapeutic relationship and collaboration. Second, a way to understand patients and their problems: besides a therapeutic relationship CBT is based on assessment and formulation. Third, a strategic posture for helping efforts: CBT is relatively short; it is problem focused and goal-oriented. CBT focuses on present- time issues therefore it is structural and directional in addition CBT is educational. The fourth, category is a skills base for implementing strategies such as: Socratic questioning, CBT makes regular use of home work tasks and it uses a verity of techniques to change thinking, mood and behaviour.

1. A base from which to help patients: therapeutic relationship and collaboration

The efficacy of cognitive and behavioral techniques is dependent, to a large degree, on the relationship between the therapist and patient. Beck et al. (1979) explain that the relationship requires therapist warmth, accurate empathy and genuineness.

The therapeutic style in CBT is very directive particularly in the early stages of therapy.

The therapist is sensitive in balancing this with communication and an empathetic understanding by being " with" the patient, together with grasping the clients meaning (Curwen, 2002). The therapeutic outcome is influences by the quality of patient-therapist relationship (Orlinsky et al., 1994). While one may get the impression that CBT is just about talking, it lays a strong emphasis on action, with a strong emphasis on the patient

assuming a central role in instigating change (Kinselle, 2008). Therefore, in any CBT intervention the focus is on intrinsic self help. According to Kinselle (2008) the aim in CBT is skill building, where the patient is taught a set of skills that can be used on a long-term basis to effectively embark upon or administer problems. Although, one cannot undermine the importance of the therapeutic relationship, it is not seen as the sole vehicle for change in CBT. A greater emphasis is placed on the patients acquiring skills during treatment and facilitating its transfer outside the sessions. The clinician is required to have precise practical skills so they can educate the patient to use these skills outside the treatment setting. To make the therapeutic relationship fruitful the use of collaboration is also important. This is seen when the patient brings their understanding of their difficulties and problems, the therapist shares their knowledge of CBT to the patient. As a therapist if you achieve the emotional level of the patients trust (" the therapist knows what he/she is doing," " I can trust them") it could be said that more than half the therapeutic relation is accomplished. With straightforward problems, if the therapist " connects" with the patient is it easy to develop a productive therapeutic coalition within the first 2 sessions. However, with co morbid, complex and personality difficulties to create a productive therapeutic alliance could take up to weeks or months (Kinselle, 2008). Once the therapist has made a fruit-full therapeutic alliance it could be easier to have an assessment and formulation of the patient.

2. A way to understand patients and their problems: assessment and formulation

Humans are predisposed to and in a constant process of assessing and appraising events and people in the first few seconds of encounter. The nature of these appraisals is habitually interpersonal for example, " Is this a person I can get on with?" etc. This implies that the process of appraisal and assessment begins in the first moments of contact between the therapist and client which means that " assessment" is only a formalization of these natural appraisal processes. However, it is important as it enables an initial formulation which in turn will provide a road map for the intervention (——–). The assessment is primarily based on five spheres of influence: life situation; relationship and practical problem; altered emotions (mood or feeling); altered thinking; distorted activity levels or behaviour; unclear physical feeling and their symptoms (Williams, 2002). The sequence of these spheres is important, as it helps the patient and therapist to devise and alter experiments and plans that the patient can utilize to bring about change (Williams, 2002). In addition, these domains of assessment help to establish a therapeutic alliance, formulate presenting problems of the patient, evaluate the patient for a course of therapy and lastly it answers specific questions from referrer.

The assessment in CBT help the patient and therapist to identify the patients core beliefs, compensatory approach, dysfunctional assumptions, behavioural patterns that maintain the presenting problem and problematic cognitive styles (Papadakis Lecture Note). The process of an assessment is done when the therapist gathers information of the client by using psychological theories to analyze the information. In addition the assessment contains a problem list by looking at the client's history- development of the

problems and collects information on presenting problems which further helps for the formulation in the therapy. This part of the assessment intends to recognize precipitating factors, vulnerability and modifying factors (Westbrook, 2008). The methods a therapist should use is clinical interview, (where a good therapeutic relationship is very important), observational methods (there are specific information to the cognitive behavioural approach where this information helps in planning the formulation and specific intervention) psychometric measures, such as the Weschler Adult Intelligence Scale (WAIS) and questionnaires such as the Standardized measures (e. g Beck Depression Inventory BDI) (Papadakis lecture notes). As information establishes to build up, there is a concomitant requirement to order it into meaningful and useful form and this is where formulation takes over (Wills, 2008).

Although most assessment takes place in the initial sessions, the process of assessment continues throughout treatment. Cognitive-behavioral assessment strategies take many forms across four domains: cognition, behavior, emotion, and physiology (Blankstein and Segal, 2001). Each assessment procedure yields specific information about a particular response system. Assessing a problem with multiple techniques produces a more comprehensive identification of the problem, and gives the therapist a better picture of how well the treatment addresses the problem (Kirk, 1989). Cognitive-behavioral assessment often begins with an initial interview (J. S. Beck, 1995; Blankstein and Segal, 2001). During this interview, the therapist clarifies the patient's problems, formulate the difficulties in manageable units that will encourage the patient to believe that change is possible.

Additionally, the assessment process helps the patient learn that variations in the intensity and distress of symptoms are predictable and potentially controllable. The assessment interview also highlights problems that should be prioritized, such as child abuse, suicidal, or problems with serious physical consequences. The initial interview may be supplemented by a variety of other assessment techniques, including self-report questionnaires, direct observation of behavior, behavioral tests, physiological measures, and self-monitoring. Selfreport questionnaires such as the Beck Depression Inventory (BDI-II; A. T. Beck et al., 1996) are easily administered and can be collected periodically throughout the therapy process. Moreover, normative data exist for many self-report questionnaires, which can help to contextualize a patient's score. A particularly useful assessment technique involves the direct observation of behavior. This can be accomplished through frequency counts, duration of symptoms or behaviors, or observations made during role-plays with the patient. Direct observation of the problem behavior can be repeated during the course of treatment to assess change. Specific behavioral tests also provide direct observation of a wide range of problem behaviors. These are indirect, objective measures that are relatively free from observer bias. While such by-products do not focus on the problem behavior itself, they do provide reliable physical evidence that the behavior has occurred.

Formulation involves synthesis of various aspects of client data that provides explanation of the origins, development and maintenance of the client's problems. It answers the clients question and provides them with a psychological rational for their problem by answering variants of questions

like: Why now? Why me? How can I get better? Why doesn't the problem just go away? (———). Formulation further helps the therapist in understanding the client and making treatment decisions (Pearson, 1989; Beck et al., 2003) based on scientific evidence, increasing treatment efficacy, making it more individualized and purposeful.

A clinical formulation enables the process of making meaning of clients' experience, while fostering a sense of hope and normalising symptoms. It also aids the mutual understanding and guides the client difficulties. Furthermore, the use of formulation promotes sympathy in the therapist. " What helps the therapist can usually also help the client" (Wills, 2008): thus, the formulation facilitates sharing: explicitness and empathy. It makes links between the present and past and helps to expose the underlying processes. Finally, it reveals gaps and missing information. Due to being an active therapy it is useful for the therapist to draw visual diagrams either on a white board or paper so the patient can put jargon words into content.

A strategic posture for help includes:

Cognitive-behavioral intervention occurs over a short term in a time-limited manner. Every attempt is made to effect change rapidly. Many treatment manuals recommend that therapeutic goals be achieved within 12-16 sessions (Chambless et al., 1996). The therapist and client address current patterns of thinking and behavior with an eye to enabling the patient to anticipate and navigate similar problems in the future. Treatment is based on present difficulties. Compared to other therapies CBT is not worried with the ways in which the patient's disorder developed in the past. However it

focuses on the factors that the disorder is being effected by at the present time of the treatment (Gelder, 2006).

Since CBT is an active therapy it is structured and problem focused. Both the therapist and patient maintain this structure throughout therapy (Westbrook, 2008). The sessions are structured via an agenda which contains a mutual agreement between the therapist and patient (Curwen, 2000). Besides the first session the layout of the agenda is the same however, the organization of the therapy will be determined by the particular problem the patients presents (Curwen, 2000). The agenda encompasses several benefits during session. It permits the therapist and patient to use their time most efficiently (Curwen, 2000). In addition, it supports teamwork by encouraging a problem solving and business like approach rather than encouraging a patient a " sick role" (Curwen, 2000).

Having a structure in CBT also helps the patient understand the central themes of CBT and how the individual could use the structure once the therapy is terminated. According to Curwen (2002) a typical structure seen in a session is as follows:

1. Confirm client's mood.

2. Brief review of week.

3. Set agenda for present session.

4. Feedback and link to, prior session.

5. Review home work.

6. Converse agenda items.

7. Set homework.

8. Inquire about feedback at end of session.

Both parties contribute to the therapy in terms of identifying problems and challenging the negative cognitions that mediate negative emotional states and maladaptive behavior (J. S. Beck, 1995). The therapist is active across a variety of tasks: questioning negative thoughts, teaching new skills, educating about the psychological disorder, modeling new behaviors, and planning homework assignments. In a similar vein, the patient is active: monitoring behavior and thought, completing homework assignments, challenging negative thoughts, practicing skills, etc. The active therapist role is one factor that distinguishes cognitive-behavioral treatments from more traditional forms of psychodynamic and psychoanalytic psychotherapy, which prescribe the therapist to follow the patient's lead in session (Meichenbaum, 1995).

As mention above the therapy allows helping maintain structure once therapy is terminated it also aids with relapse prevention and it helps by planning obstacles in advance so the patient can overcome the situation out side therapy in " real life" situations.

A person's orientation to his or her problems determines the manner in which a person processes information about the self, the environment, and problematic situations encountered in everyday life. Problem orientation, or attitude toward problem solving, involves the ability to (a) ward off negative

emotions (e. g., anxiety, depression, and anger) that hamper problem-solving efforts, (b) promote positive emotions and a sense of competency that facilitate problem solving, and (c) motivate an individual toward solving problems (D'Zurilla & Nezu, 1990; D'Zurilla & Sheedy, 1991; Nezu & D'Zurilla, 1989).

According to D'Zurilla & Goldfried, (——), conceptualized problem-solving therapy is a form of self-control training, emphasizing the importance of training the client to function as his /her own therapist. Problem-solving refers to an overt or cognitive process that makes available a variety of effective response alternatives for coping with a problem situation and increases the likelihood of selecting the most effective response available. They identified five overlapping stages as representative of the problem-solving process: (1) general orientation or " set" (2) problem definition and formulation (3) generation of alternatives (4) decision making and (5) verification. Training in problem solving involves teaching clients these basic skills and guiding their application in actual problem situations

As mentioned earlier CBT is time framed therapy therefore, according to Westbrook (2008) to maintain the efficacy as a time limited therapy the agreement to work towards mutually agreed goals in early stages of therapy is important. The patient and therapist set explicit goals for the therapy at the outset of treatment. Typically, the patient will desire a reduction in distressing symptoms. The treatment is tailored to the patient's specific set of circumstances, such that any number of problems could be targeted for intervention. Goals such as increasing positive experiences, building coping future problems, and prevention of relapse are within the purview of

cognitive-behavioral therapies. Goal setting focuses the patient's thinking upon gains she can achieve through therapy, and can prompt a discussion of the realistic limits of therapy. For example, the goal of ' never having anxiety again' is unrealistic, as is the goal of ' never being sad again.' Throughout the course of therapy, the patient and therapist can revisit the goals to asses the progress of therapy, revising the goals, if need be, in the face of changing life circumstances.

It is axiomatic within cognitive-behavioral approaches that patients are seen as capable of controlling their own thoughts and actions. Therapy, under this assumption, becomes an educative process aimed at helping the patient acquire skills and knowledge that will enable her to function more adaptively (D'Zurilla and Goldfried, 1971). The therapist may instruct the patient throughout treatment for example, regarding the nature and course of the disorder, as well as the rationale behind specific interventions. The educative interaction between the therapist and patient is another factor that sets cognitive-behavioral therapies apart from other schools of therapy (Mahoney, 1974; Beck et al., 1979; DeRubeis et al., 2001).

CBT is a skills base for implementing strategies

In cognitive behvioural therapy, effective interaction between therapist and patient is best accomplished by frequent use guided discovery. The involvement of guided discovery encompassed of asking questions which invites the patient to investigate what she/he is saying and then looking at the situation from a different perspective or " out side the box" this is Socraratic Dialogue (Wills, 2008). Through this patients are guided through a

process of discovering their distorted patterns of thinking and behaving. Is Socratic questioning the therapist barely ever expresses their own judgment but asks questions which make the patient think more deeply (Wills, 2008). However, the therapist asks questions that they know the patients would be able to answer. Because CBT is an interactive therapy, according to Wills, 2008 during therapy having a list of Socratic questions on hand for both patient and therapist makes therapy more effective.

As skill acquisition requires practice, the patient is encouraged to work on a variety of therapeutic tasks outside of the session. The therapist frames these tasks, or homework assignments, as a vital component of treatment that is crucial to its success (J. S. Beck, 1995). The therapist and patient formulate the homework assignments together, customizing each task to the patient's problems and skill set. The therapist clarifies the rationale for each homework assignment and gives specific instructions, allowing the patient to express objections. Whenever possible, the therapist and patient anticipate problems that might hinder completion of the homework task. As homework tasks reinforce and supplement the educational aspects of the therapy, it is important that the patient experience each assignment as a relative success (A. T. Beck et al., 1979; J. S. Beck, 1995).

Cognitive-behavioral therapies require both patient and therapist to take an active role in the moment-by-moment progress of the treatment. These techniques are seen in self-monitoring which is an important assessment tool. The therapist instructs the patient to observe and record their own behavioral and emotional reactions. J. S. Beck, 1995 mentions as these reactions are distributed throughout the patient's daily life, self monitoring

tends to be employed as a homework assignment. The therapist and patient collaboratively select the target of monitoring (e. g., a symptom, behavior, or reaction) based upon the patient's goals and presenting problem list. Self-monitoring serves at least three purposes within a course of CBT: (1) it encourages and effectively trains the patient to observe her own reactions in a more scientific manner; (2) it renders a concrete record of the target symptoms and problems; and (3) new problems can become apparent and targeted for future intervention. Self-monitoring is especially useful in early sessions as a means of assessing the severity or frequency of a particular problem or symptom. However, self-monitoring is equally useful in later sessions as a means of tracking the patient's progress. Examples of self monitoring include a record of daily activities and corresponding mood; a frequency count of the number of panic attacks per day; a record of the frequency and content of auditory hallucinations; and a food diary in which time, quantity, and type of food eaten are recorded.

Another technique used is problem solving is a self-directed process by which a person attempts to identify or discover effective or adaptive solutions for specific problems encountered in everyday life. According to D'Zurilla and Goldfried, 1971 initially, the therapist helps the patient identify and define the problems they face. For each problem, the therapist and patient brainstorm potential solutions, evaluate the quality of each solution, and test out the best solution. Problem solving also entails helping the patient identify and overcome difficulties (practical and cognitive) that he/she might encounter while carrying out the plan. Where testing and evaluation of possible solutions indicates that they are inappropriate, patient

and therapist develop either modified or new solutions (D'Zurilla and Nezu, 1980; Hawton and Kirk, 1989). Problem solving is easily learned and has been applied to a wide range of situations commonly encountered in psychiatric practice: example applications include difficulties associated with mood, anxiety, stress, substance abuse, psychotic symptoms and other health problems (D'Zurilla and Nezu, 2001).

Many disorders are characterized by waxing and waning symptomatology.

Preparing clients for the possibility that the problem symptoms will return is, accordingly, an important phase of therapy. CBT gives an emphasis on teaching the patient to become their own therapist (Westbrook, 2008). Central to the relapse prevention model is the distinction between a lapse and a relapse. A lapse is defined as a single isolated emergence of a symptom (e. g., a violation of abstinence), while a relapse is defined as a full-blown return of the pretreatment symptom levels (e. g., addictive behavior) (Marlatt and Gordon, 1995). A lapse does not inexorably lead to relapse, the therapist and patient can work together to develop skills and strategies to neutralize the lapses that will undoubtedly occur following successful CBT treatment. An equally important application of relapse prevention techniques is to help patients test out whether they have developed realistic expectations of their own ability to cope outside therapy (Young et al., 2003), as unrealistic optimism may be a risk factor for relapse (Alvarez-Conrad et al., 2002). According to Ellis and Newman, (1996), relapse prevention consists of four components: (1) identifying high-risk situations; (2) learning coping skills; (3) practicing coping skills; and (4) creating life-style balance. Following the ethos of relapse prevention, the therapist

encourages the patient to frame inevitable setbacks as learning experiences within the therapeutic process rather than as personal failures or treatment failures. Therapist and patient anticipate and identify high-risk situations-those which are most likely to trigger relapse-and rehearse coping strategies that can be used in the event that such circumstances occur. Imaginable techniques, importantly, can be employed: the patient vividly imagines a situation that could trigger relapse, applying the coping strategies to see if they effectively neutralize the advancing dysphoria