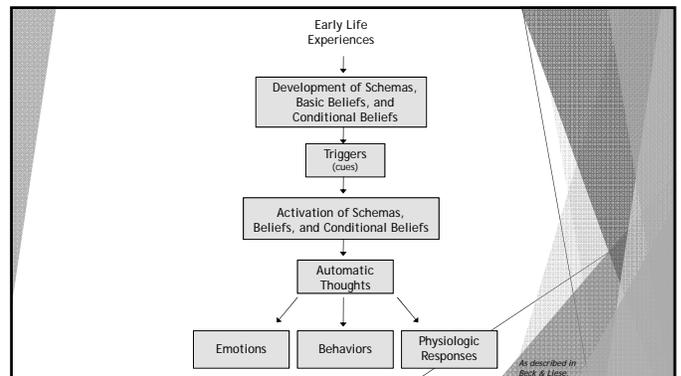
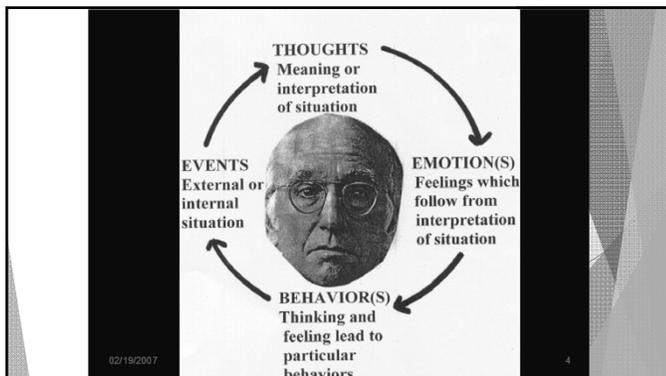


# CBT for everyday clinical practice

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## What is CBT?

- ▶ RET developed by Ellis from 1950s onwards
- ▶ Cognitive Therapy developed by Beck from early 1960s onwards
- ▶ Inclusion of cognition in Behavior Therapy in 1970s (Meichenbaum, Mahoney) and subsequently
- ▶ Inclusion of 3<sup>rd</sup> wave (ACT, DBT, Mindfulness)
- ▶ Augmentation by Motivational Interviewing



## Basic assumptions of CBT.

- ▶ Cognitions (negative thoughts, images, beliefs) can powerfully effect emotions, behavior and even physiology.
- ▶ Interpretation of or assumptions about events can add to the distress of the event itself.
- ▶ In different disorders there are distinctive and characteristic cognitive themes.
- ▶ In disorders of mood and emotion there are often distortions or biases in how these clients think which give rise to negative thoughts
- ▶ Individuals are often predisposed to certain ways of thinking as result of beliefs often learned through early experience.

## Examples of cognitive model

- ▶ Epicetus " Men are not disturbed by things but by their view of them"
- ▶ Marcus Aurelius " The happiness of your life depends on the quality of your thoughts"
- ▶ The Buddha " We are what we think. With our thoughts we make the world"
- ▶ Shakespeare "There is nothing either bad or good but thinking makes it so"
- ▶ The Bible " As a man thinketh in his heart, so is he".

## Proverbs which are compatible with the Cognitive model

- ▶ One man's meat is another man's poison
- ▶ All looks yellow to the jaundiced eye
- ▶ Every eye forms its own beauty

## Components of cognitive model

### NEGATIVE AUTOMATIC THOUGHTS:

\* Specific negative thoughts, memories and images related to specific precipitating situations.  
Examples: " I am stupid", " She hates me", " I will screw up this job".

### COGNITIVE DISTORTIONS:

- Information-processing biases or thinking errors influenced by beliefs.

Examples: Overgeneralization, All-or-nothing thinking, Mind Reading, Mental Filter, Catastrophizing.

### DYSFUNCTIONAL BELIEFS\SCHEMAS

- ▶ General assumptions or ways of looking at the world by which experiences are viewed and interpreted

Examples: " No one can be trusted"  
" The world is full of danger"  
" I am unworthy"  
" I am incompetent"

## STYLE OF COGNITIVE BEHAVIOR THERAPY

- ▶ Structured (agenda, systematic approach)
- ▶ Collaborative, not confrontational
- ▶ Problem-oriented and symptom-relief focus (later schema modification)
- ▶ Collaborative empiricism
- ▶ Questioning\guided discovery
- ▶ Active and directive
- ▶ Explicit and open
- ▶ Feedback regularly elicited

## CBT is active and involves problem-solving not just insight



## Cognitive Therapy Myths

Myth 1: CBT is synonymous with "the power of positive thinking"

Myth 2: The cognitive theory of psychopathology claims that negative thoughts cause psychopathology

Myth 3: CBT is talking people out of their problems

Myth 4: CBT ignores emotion and behavior

Myth 5: CBT ignores the past

## Cognitive Behavior Therapy Myths

- ▶ Myth 6: The therapeutic relationship is not important in CBT
- ▶ Myth 7: CBT is finished in 15 sessions or less
- ▶ Myth 8: CBT means no medication
- ▶ Myth 9: The goal of CBT is to eliminate emotion
- ▶ Myth 10: CBT is only appropriate for bright, intellectually oriented clients

## Who does it work for and how well

- ▶ Well-established applications, where about 70% in research trials and clinical practice benefit significantly
  - ▶ Depression, Anxiety Disorders (adult and child, relapse rates 50% less than other treatments)
- ▶ Other proven applications
  - ▶ Substance abuse, eating disorders, couple problems, personality disorders, medical conditions such as pain, hypertension and IBS
- ▶ Newer, emerging applications
  - ▶ Psychosis, bipolar disorder, autism spectrum disorders, hair pulling and medical issues including cancer, diabetes and medical compliance.

## What CBT can target in medical or non-psychiatric patients

- ▶ External/situational factors (environment, family, social)
  - ▶ COGNITIONS (thoughts & beliefs): Meaning of condition/disorder, model of disorder, beliefs re course, tx, prognosis, sense of self, resources to deal with disorder
  - ▶ EMOTIONS connected to disorder: depression, anxiety, frustration, anger, disorder-induced stress
  - ▶ BEHAVIORS: At risk behaviors, coping behaviors, compliance with Tx, communication, life style modification
- ▶ All of the above can be identified and worked with as  
(1) precipitants or factors creating the condition, (2) factors which maintain the condition or (3) consequences of the condition/disorder

## CBT Case Conceptualization

- ▶ List problems client wants help with
- ▶ Dismantle each problem into
  - situation
  - feelings/emotions
  - thoughts/images
  - behavioral component
- ▶ Collaboratively select appropriate target for intervention
- ▶ Select appropriate intervention for each target

## Identifying Thoughts: 4 Questions

Create situation-thought-feeling-behavior link  
Steps:

- ▶ Identify a problem area.
- ▶ Focus on a specific occurrence of this problem.
- ▶ Identify the situation.  
(1) "What was going on?"
- ▶ Identify the emotions.  
(2) "What exactly were you feeling?"

- ▶ Identify thoughts/images  
(3) "What went through your mind/what were you thinking about as you were \_\_\_\_\_ (situation) and started to feel \_\_\_\_\_ (emotion)?"
- ▶ Identify behavior:  
(4) "What did you do?"

## Key Questions which promote and facilitate a cognitive shift

- ▶ What's the evidence ? (Validity)
- ▶ Is there an alternative view ? (Flexibility)
- ▶ What's the worst that might happen and how likely (Probabilistic Reasoning)
- ▶ What's the effect of thinking this way ? (Functionality)
- ▶ What can I do? (Action)

## Cognitive reframing



## Another example of reframing



## Alternative to cognitive shift

- ▶ Acceptance
- ▶ Mindfulness
- ▶ Cognitive defusion

## Evidence Review

Purpose: To help client test out their automatic thoughts which involve a general conclusion (example " I have failed at everything")

- Steps:
- \* Identify the exact conclusion the client has drawn and degree of belief
  - \* Define terms ("What do you mean by failed?")
  - \* List all evidence to support this conclusion

- \* List all evidence that does not support this conclusion
- \* Discuss if further information is needed to test out original thought
- \* Review original thought and degree of belief in the light of the evidence review.

## Generating alternative viewpoints

Purpose: To help clients who negatively misinterpret situations to consider alternative explanations or interpretations which have different emotional consequences.

- Steps:
- \* Identify the exact interpretation of the situation ("My friend not texting me back means we are done") made by the client
  - \* Encourage the client to brainstorm all other possible explanations
  - \* Discuss evidence for each alternative

## Thought Utility Test

Purpose: to help clients evaluate the negative and positive effects of their thoughts\beliefs and to revise them, needed.

- Steps:
- \* Identify a belief or a theme underlying clients' thoughts ("No one can be trusted")
  - \* List advantages\disadvantages of holding this belief (How does it help or hinder?)

- Review advantages\disadvantages in terms of overall utility (does it help more than hinder?)
- \* Encourage client to generate a revised version of this belief to change the cost-benefit ratio

## Recognizing Thinking Distortions

Purpose: To help patients recognize how their thinking style influences their problems and to facilitate distancing and re-appraising automatic thoughts.

- Steps:
- \* Familiarize client with concept of cognitive distortions
  - \* Supply handout listing these with examples.

- \* In session: Ask client to identify from negative thoughts collected any distortions involved ("The thought you had about ----- Does that seem similar to any of those on the list?")
- \* Homework assignment: Complete a 4<sup>th</sup> column (distortions) on situation-mood-thoughts record).

## De-catastrophizing

Purpose: To assist client's who predict worst case scenario or engage in "what if" thinking consider probabilities and outcomes realistically.

- Steps:
- \* Ascertain exactly what client believes is the worst outcome in a specific situation ("People will not think well of me if I stutter")
  - \* Ensure that this predicted catastrophe is the worst the client can imagine

- \* Get client to also consider (a) the best outcome and (b) the most likely outcome based on past experience.
- \* Get client to rate the likelihood of each outcome actually occurring
- \* Inquire how awful the worst case scenario would actually be and how they could cope or recover if it were to happen.

## Behavioral Interventions

- ▶ Activity\pleasure scheduling:-Low levels of activity or pleasure maintain depression
- ❖ Graded Assignments:- Disorganization or being overwhelmed prevents task completion.
- ❖ Exposure:- Avoidance of situations or thoughts\feelings leads to problems.
- ❖ Self-regulation skills:- Physiological\somatic over-arousal (anxious or dysregulated clients)
- ❖ Problem solving training:-Deficits at any of the stage effective problem solving.
- ❖ Skills training:-Specific skill deficits (social skills, communication, assertiveness)

## Graded Assignments

Purpose: To help clients who are overwhelmed, lacking in motivation or disorganized achieve their goals.

Steps:

- ▶ List tasks or activities client wants to complete
- ▶ Prioritize this list in order of importance or perceived benefit
- ▶ Break down each activity or task into small steps

- ▶ Schedule day and time to complete each step in order
- ▶ Assign homework to record each completed step and sense of accomplishment
- ▶ Ensure client rehearses plan to deal with possible all-or-nothing thinking and other traps which can sabotage this approach.

## Problem solving strategy

- ▶ Describe stages of successful problem solving
  - Select problem and establish goal
  - Generate options: (brainstorm, don't judge)
  - Evaluate each option (pros and cons)
  - Select most promising option and implement it
  - Review outcome and reconsider original problem in light of outcome
  - Return to next ranked option(s), if necessary

## Arousal Reduction Methods

Purpose: To assist patients in managing high levels of autonomic over arousal.

Methods:

- ▶ Progressive Muscle Relaxation
- ▶ Applied Relaxation
- ▶ Breathing Retraining
- ▶ Guided Imagery
- ▶ Mindfulness and related techniques

## Exposure Methods

- ▶ Purpose: To change beliefs of clients who avoid situations (or feelings) due to a predicted catastrophe and to allow anxiety to habituate
- ▶ Steps:
  - \* Find out what is being avoided
  - \* Identify feared catastrophe
  - \* Devise a hierarchy of anxiety-inducing situations

- \* Set up exposure tasks with specific hypothesis to be tested
- \* Review possible outcomes and rehearse coping strategies
- \* Complete exposure task
- \* Consider outcome in terms of test of hypothesis: implications of disconfirmation

- ▶ Thank you for attending
- ▶ Be well and do good (CBT?) work
- ▶ More info:
- ▶ Recommended readings and websites, free podcasts at [www.behaviortherapist.com](http://www.behaviortherapist.com)

Questions? Email [jludgate@behaviortherapist.com](mailto:jludgate@behaviortherapist.com)