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WHAT YOU ALWAYS WANTED TO KNOW ABOUT CBT,

BUT WERE AFRAID TO ASK

First Question: What is CBT?
Answer: Cognitive-Behavioral Therapy

There are several appealing features to this approach to dealing with people in distress. For one thing, CBT is easy to use; for another, it is evidence-based and compares favorably with other forms of therapy and medications. It is designed to help patients cope with depression, anxiety and other mental health problems, including addiction.

In 1979, Aaron Beck, MD,[1] published his classic book, "Cognitive Therapy of Depression," where he voiced his frustration with the failure rate of psychoanalytic therapy, especially with depression.

His first insight was that depressed patients hold unrealistically negative views about themselves. Utilizing understandings derived from computer science, he next realized that information processing in the brain is distorted and resistant to correction. He called this kind of thinking, "automatic thoughts," that operate like reflexes. And he identified two categories:

- Intermediate beliefs (conditional)
- Core beliefs (fundamental)

Beck labeled a package of negativity about self or the world, "schema." He realized that theoretically this packet of negative cognitive content and biased information-processing would strongly influence what the patient remembers of past experiences, how he processes new experiences, and then stores them in memory. The "schema" would remain quiet during normal mood periods but then get activated by: 1. External stress – from persons, places or things that contain symbolic meaning; 2. Internal stress – where physiologic responses such as rapid heart beat, shallow rapid breathing, dizziness, GI upset, from any cause are the stand-in for the feared or undesired thing, e.g. bumpy air in the flight leads to rapid heart, meaning (in the patient's mind) "about to crash and die;" cancelled date leads to sad emotion meaning the patient is

"worthless."

Cognitive science teaches that thoughts, feelings and behaviors are mutually interactive by feedback loops. Change the thought or behavior and you can actually change the emotion.

What are the chief Guiding Principles of Cognitive Behavioral Therapy?[2]

1. The therapist uses the Cognitive Model to create new meanings where the former distorted thinking created dysfunctional, maladaptive meanings.
2. Therapy sessions are structured and goal-oriented rather than amorphous and free flowing as with free-association.
3. The therapist works in an active mode rather than as a passive listener. He uses problem-solving techniques to help the patient change thoughts, feelings and behavior.
4. The patient is also an active participant by acquiring new skills through homework, practice and direct experience.
5. Sessions tend to be time-limited to lend a note of urgency to the treatment.
6. The patient becomes empowered and self-reliant by means of mastery and change.

Some techniques used in CBT:

A. Thought Records: The patient is instructed to keep a journal and record instances of strong negative emotion. This is a here-and-now technique rather than looking through the retrospectascope for childhood traumas. This technique helps the patient identify verbal self-messages as "you are a loser" or "you always drop the ball in the outfield." Guided Discovery and Socratic Questioning help the patient identify automatic negative thoughts and help diminish their absoluteness and their tendency to lead toward emotional distress and dysfunctional behavior.

- Some examples of Socratic Questioning:

    1. How strongly do you believe this to be true, 1 to 10?
    2. How does this thought affect the way you feel and act?
    3. Can you describe any experiences where this thought was not completely true?
    4. If you told a close friend or relative about this thought, what would they say?

- Non-Socratic Approach:
    1. Don't be so hard on yourself.
    2. You are not seeing yourself accurately.
    3. Would a "loser" have been able to graduate from college?

B. Examples of Labels for distorted thoughts:

- Overgeneralization: the patient drops the ball in the outfield: "I can't do anything

right."

- Mind reading: the teacher does not call on the student to give the answer: "She thinks I'm stupid."
- All-or-nothing thinking: well-liked by members of the club, snubbed b y one member: "None of them like me" or "I'm a social misfit."
- Catastrophization: dizzy sensation on hearing bad news: "I must have a brain tumor."

Techniques for restructuring negative beliefs:

Automatic thoughts that come from intermediate or conditional beliefs tend to be restructured quickly and fairly easily, utilizing some of the techniques already mentioned.

Core beliefs tend to be more intractable and may take several months for change. Some of the approaches include role-play, "empty chair dialogue" from Gestalt therapy, and other more technical and professionally acquired skills.

Resources:

For clinicians:

- Academy of Cognitive Therapy. Training and certification as a cognitive therapist. www.academyofct.org.
- Behavior Online. Bulletin board for Mental Health professionals. www.behavior.net.

For patients:

- Beck Institute. www.beckinstitute.org has educational materials for clinicians and consumers.
- "Getting Your Life Back: the Complete Guide to Recovery from Depression" (Wright and Basco 2001)
- "Feeling Good Handbook. Burns DD. New York: Penguin; 1999.
- Mindstreet. www.mindstreet.com supplies materials for computer-assisted CBT and also has information on the basic concepts of CBT.

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1 Beck J. Cognitive therapy: basics and beyond. New York: Guilford Press; 1995.

2 Lau MA, Segal ZV, Zaretsky AE. Cognitive-behavioral therapies for the medical clinic. In: Moss D, et al. (eds) Handbook of mind-body medicine for primary care. Thousand Oaks, CA. Sage Publications; 2003:167-79.