Cognitive Behavioral Therapy: Rewire Your Mind for Change

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Cognitive behavioral therapy (CBT) is a psychotherapeutic approach: a talking therapy. CBT aims to solve problems concerning dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure in the present. The title is used in diverse ways to designate behavior therapy, cognitive therapy, and to refer to therapy based upon a combination of basic behavioral and cognitive research.

There is empirical evidence that CBT is effective for the treatment of a variety of problems, including mood, anxiety, personality, eating, substance abuse, and psychotic disorders. Treatment is often manualized, with specific technique-driven brief, direct, and time-limited treatments for specific psychological disorders. CBT is used in individual therapy as well as group settings, and the techniques are often adapted for self-help applications. Some clinicians and researchers are more cognitive oriented (e.g. cognitive restructuring), while others are more behaviorally oriented (in vivo exposure therapy). Other interventions combine both (e.g. imaginal exposure therapy).

CBT was primarily developed through a merging of behavior therapy with cognitive therapy. While rooted in rather different theories, these two traditions found common ground in focusing on the "here and now", and on alleviating symptoms. Many CBT treatment programs for specific disorders have been evaluated for efficacy; the health-care trend of evidence-based treatment, where specific treatments for symptom-based diagnoses are recommended, has favored CBT over other approaches such as psychodynamic treatments. In the United Kingdom, the National Institute for Health and Clinical Excellence recommends CBT as the treatment of choice for a number of mental health difficulties, including post-traumatic stress disorder, OCD, bulimia nervosa, and clinical depression.

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History

Precursors of certain fundamental aspects of CBT have been identified in various ancient philosophical traditions, particularly Stoicism. For example, Beck's original treatment manual for depression states, "The philosophical origins of cognitive therapy can be traced back to the Stoic philosophers". The modern roots of CBT can be traced to the development of behavior therapy in the early 20th century, the development of cognitive therapy in the 1960s, and the subsequent merging of the two. Behavior therapeutical approaches appeared as early as 1924, with Mary Cover Jones' work on the unlearning of fears in children. In 1937 Abraham Low developed cognitive training techniques for patient aftercare following psychiatric hospitalization. Low designed his techniques for use in his organization, Recovery International, which supports people recovering from mental illness. Although Recovery International was originally led by Low, he later adapted the techniques for use in lay-run self-help groups operating under the same name.

It was during the period 1950 to 1970 that behavioral therapy became widely utilized, with researchers in the United States, the United Kingdom and South Africa who were inspired by the

behaviorist learning theory of Ivan Pavlov, John B. Watson and Clark L. Hull. In Britain, this work was mostly focused on the neurotic disorders through the work of Joseph Wolpe, who applied the findings of animal experiments to his method of systematic desensitization, the precursor to today's fear reduction techniques. British psychologist Hans Eysenck, inspired by the writings of Karl Popper, criticized psychoanalysis in arguing that "if you get rid of the symptoms, you get rid of the neurosis", and presented behavior therapy as a constructive alternative. In the United States, psychologists were applying the radical behaviorism of B. F. Skinner to clinical use. Much of this work was concentrated towards severe, chronic psychiatric disorders, such as psychotic behavior and autism.

Although the early behavioral approaches were successful in many of the neurotic disorders, they had little success in treating depression. Behaviorism was also losing in popularity due to the so-called "cognitive revolution". The therapeutic approaches of Albert Ellis and Aaron T. Beck gained popularity among behavior therapists, despite the earlier behaviorist rejection of "mentalistic" concepts like thoughts and cognitions. Both these systems included behavioral elements and interventions and primarily concentrated on problems in the present. Albert Ellis's system, originated in the early 1950s, was first called rational therapy, and can arguably be called one of the first forms of cognitive behavioral therapy. It was partly founded as a reaction against popular psychotherapeutic theories at the time, mainly psychoanalysis. Aaron T. Beck, inspired by Albert Ellis, developed cognitive therapy in the 1960s. Beck describes his therapeutic approach as originating in a realization he made while conducting free association with patients in the context of classical psychoanalysis--he noted that patients had not been reporting certain thoughts at the fringe of consciousness, thoughts which often preceded intense emotional reactions; this realization led Beck to begin viewing emotional reactions as resulting from cognitions, rather than understanding emotion within the abstract psychoanalytic framework. Cognitive therapy rapidly became a favorite intervention technique to study in psychotherapy research in academic settings. In initial studies, it was often contrasted with behavioral treatments to see which was most effective. During the 1980s and 1990s, cognitive and behavioral techniques were merged into cognitive behavioral therapy. Pivotal to this merging was the successful development of treatments for panic disorder by David M. Clark in the UK and David H. Barlow in the US.

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Concurrently with the contributions of Ellis and Beck, starting in the late 1950s and continuing through the 1970s, Arnold A. Lazarus developed what was arguably the first form of broad-spectrum cognitive behavioral therapy. He later broadened the focus of behavioral treatment to incorporate cognitive aspects.

Arnold Lazarus, desiring to optimize therapy's effectiveness and effect durable treatment, cognitive and behavioral methods, developed a new form of therapy called multimodal therapy, based on CBT, but also including physical sensations (as distinct from emotional states), visual images (as distinct from language-based thinking), interpersonal relationships, and biological factors.

Samuel Yochelson and Stanton Samenow pioneered the idea that cognitive behavioral approaches can be used successfully with a criminal population. They are the authors of Criminal Personality Vol. I. This book has an extensive amount of information regarding the dynamics of criminal thinking and application of cognitive behavioral approaches.

Approaches and systems

CBT includes a variety of approaches and therapeutic systems; some of the most well known include cognitive therapy, rational emotive behavior therapy and multimodal therapy. Defining the scope of what constitutes a cognitive-behavioral therapy is a difficulty that has persisted throughout its development.

The particular therapeutic techniques vary within the different approaches of CBT according to the particular kind of problem issues, but commonly may include keeping a diary of significant events and associated feelings, thoughts and behaviors; questioning and testing cognitions, assumptions, evaluations and beliefs that might be unhelpful and unrealistic; gradually facing activities which may have been avoided; and trying out new ways of behaving and reacting. Relaxation, mindfulness and distraction techniques are also commonly included. Cognitive behavioral therapy is often also used in conjunction with mood stabilizing medications to treat conditions like bipolar disorder. Its application in treating schizophrenia along with medication and family therapy is recognized by the NICE guidelines (see below) within the British NHS.

Going through cognitive behavioral therapy generally is not an overnight process for clients; a typical course consists of 12-16 hour-long sessions. Even after clients have learned to recognize when and where their mental processes go awry, it can in some cases take considerable time or effort to replace a dysfunctional cognitive-affective-behavioral process or habit with a more reasonable and adaptive one. Cognitive Behavioral Therapy is problem focused and structured towards the client, it requires honesty and openness between the client and therapist, as a therapist develops strategies for managing problems and guiding the client to a better life.

Computerized

There are cognitive behavioral therapy sessions in which the user interacts with computer software (either on a PC, or sometimes via a voice-activated phone service), instead of face to face with a therapist. This can provide an option for patients, especially in light of the fact that there are not always therapists available, or the cost can be prohibitive. For people who are feeling depressed and withdrawn, the prospect of having to speak to someone about their innermost problems can be off-putting. In this respect, computerized CBT can be a good option.

Randomized controlled trials have proven its effectiveness, and in February 2006 the UK's

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National Institute for Health and Clinical Excellence recommended that CCBT be made available for use within the NHS across England and Wales, for patients presenting with mild to moderate depression, rather than immediately opting for antidepressant medication.

Specific applications

CBT has been applied within many clinical and non-clinical environments and has been successfully used as a treatment for many clinical disorders, personality conditions and behavioral problems. CBT is highly effective for a number of disorders and it is important to note that cognitive behavioral therapy is unlikely to be effective in treating psychiatric problems caused solely by drug or alcohol abuse. It has been argued that the treatment of such patients should be directed at tackling their substance abuse problems (ideally aiming for complete abstinence) prior to the commencement of CBT.

Anxiety disorders

A basic concept in CBT treatment of anxiety disorders is in vivo exposure--a gradual exposure to the actual, feared stimulus. This treatment is based on the theory that the fear response has been classically conditioned and that avoidance negatively reinforces and maintains that fear. This "two-factor" model is often credited to O. Hobart Mowrer. Through exposure to the stimulus, this conditioning can be unlearned; this is referred to as extinction and habituation. CBT also looks at an individual's way of thinking and the way that he or she reacts to certain habits or behaviors. A specific phobia, such as fear of spiders, can often be treated with in vivo exposure and therapist modeling in one session. Obsessive compulsive disorder is typically treated with exposure with response prevention.

Social phobia, also known as social anxiety, has often been treated with exposure coupled with cognitive restructuring, such as in Heimberg's group therapy protocol. Evidence suggests that cognitive interventions improve the result of social phobia treatment.

CBT has been shown to be effective in the treatment of generalized anxiety disorder, and possibly more effective than pharmacological treatments in the long term. In fact, one study of patients undergoing benzodiazepine withdrawal who had a diagnosis of generalized anxiety disorder showed that those who received CBT had a very high success rate of discontinuing benzodiazepines compared to those who did not receive CBT. This success rate was maintained at 12-month follow up. Furthermore in patients who had discontinued benzodiazepines, it was found that they no longer met the diagnosis of general anxiety disorder and that patients no longer meeting the diagnosis of general anxiety disorder was higher in the group who received CBT. Thus CBT can be an effective tool to add to a gradual benzodiazepine dosage reduction program leading to improved and sustained mental health benefits.

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Mood disorders

One etiological theory of depression is Aaron Beck's cognitive theory of depression. His theory states that depressed people think the way they do because their thinking is biased towards negative interpretations. According to this theory, depressed people acquire a negative schema of the world in childhood and adolescence as an effect of stressful life events. When the person with such schemata encounters a situation that in some way resembles the conditions in which the original schema was learned, the negative schemata of the person are activated.

Beck also described a negative cognitive triad, made up of the negative schemata and cognitive biases of the person; Beck theorized that depressed individuals make negative evaluations of themselves, the world, and the future. Depressed people, according to this theory, have views such as, "I never do a good job", "It is impossible to have a good day", and "things will never get better." A negative schema helps give rise to the cognitive bias, and the cognitive bias helps fuel the negative schema. This is the negative triad. Also, Beck proposed that depressed people often have the following cognitive biases: arbitrary inference, selective abstraction, over-generalization, magnification and minimization. These cognitive biases are quick to make negative, generalized, and personal inferences of the self, thus fueling the negative schema.

Cognitive behavioral therapy has been shown as an effective treatment for clinical depression. A large-scale study in 2000 showed substantially higher results of response and remission (73% for combined therapy vs. 48% for either CBT or the antidepressant Nefazodone alone) when a form of cognitive behavior therapy and that particular discontinued anti-depressant drug were combined than when either modality was used alone.

For more general results confirming that CBT alone can provide lower but nonetheless valuable levels of relief from depression, and result in increased ability for the patient to remain in employment, see The Depression Report, which states: 100 people attend up to sixteen weekly sessions one-on-one lasting one hour each, some will drop out but within four months 50 people will have lost their psychiatric symptoms.

The American Psychiatric Association Practice Guidelines (April 2000) indicated that among psychotherapeutic approaches, cognitive behavioral therapy and interpersonal psychotherapy had the best-documented efficacy for treatment of major depressive disorder.

Recently some CBT practitioners have returned to more behavioral approaches to the treatment of depression such as behavioral activation. A large-scale treatment study found behavioral activation to be more effective than cognitive therapy and on a par with medication for treating depression.

Insomnia

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Cognitive Behavioral Therapy for Insomnia (CBT-I) has been found to be effective in reducing benzodiazepine usage in the treatment of insomnia. A large-scale trial utilizing CBT-I for chronic users of sedative hypnotics including nitrazepam, temazepam and zopiclone found the addition of CBT-I to improve outcome and reduce drug consumption in the treatment of chronic insomnia. Persisting improvements in sleep quality, sleep latency, and increased total sleep, as well as improvements in sleep efficiency and significant improvements in vitality and physical and mental health at 3-, 6- and 12-month follow-ups were found in those receiving cognitive behavioral therapy for insomnia with hypnotics compared with those patients receiving hypnotics alone. A marked reduction in total sedative hypnotic drug use was found in those receiving CBT-I, with 33% reporting no hypnotic drug use. Authors of the study suggested that CBT-I is potentially a flexible, practical, and cost-effective treatment for the treatment of insomnia and that CBT-I administered coincident to hypnotic treatment leads to a reduction of benzodiazepine drug intake in a significant number of patients. Chronic use of hypnotic medications is not recommended due to their adverse effects on health and the risk of dependence. A gradual taper is usual clinical course in getting people off benzodiazepines but even with gradual reduction a large proportion of people fail to stop taking benzodiazepines. The elderly are particularly sensitive to the adverse effects of hypnotic medications. A clinical trial in elderly people dependent on benzodiazepine hypnotics showed that the addition of CBT-I to a gradual benzodiazepine reduction program increased the success rate of discontinuing benzodiazepine hypnotic drugs from 38% to 77% and at 12-month follow-up from 24% to 70%. The paper concluded that CBT-I is an effective tool for reducing hypnotic use in the elderly and reducing the adverse health effects that are associated with hypnotics such as drug dependence, cognitive impairments and increased road traffic accidents.

A further study in older people with insomnia comparing the hypnotic drug zopiclone against CBT-I found that CBT-I actually improved EEG slow wave sleep as well as increased time spent asleep and found that the benefits were maintained at 6-month follow-up. Zopiclone however worsened sleep by suppressing slow wave sleep. A lack of slow wave sleep is linked to impaired functioning and sleepiness. Zopiclone reduced slow wave sleep and was similar to placebo in that it produced no lasting benefits after treatment had finished and at 6-month follow-up while CBT-I did have significant lasting benefits. The authors stated that CBT-I was superior to zopiclone both in the short term and in the long term. A comparison of CBT-I and the hypnotic drug zolpidem (Ambien) found similar results with CBT-I showing superiority and sustained benefits after long term follow up. Interestingly the addition of CBT-I and zolpidem offered no benefit over CBT-I alone.

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Severe mental disorders

Several meta-analyses have shown CBT effective in schizophrenia and the American Psychiatric Association includes CBT in its schizophrenia guideline as an evidence-based treatment. There is also some limited evidence of effectiveness for CBT in bipolar disorder and severe depression.

However, in a 2010 article in Psychological Medicine entitled, Cognitive behavioral therapy for the major psychiatric disorder: does it really work?, the authors found that no trial employing both blinding and psychological placebo has found CBT to be effective in schizophrenia. The authors also found few well-controlled studies of CBT in depression that found the therapy to be effective, and in those found, the effect was small. CBT is also ineffective in preventing relapses in bipolar disorder.

Children and adolescents

The use of CBT has been extended to children and adolescents with positive results. CBT is one of the few empirically-supported psychosocial treatments for young people CBT for Children and Adolescents". It is often used to treat major depressive disorder, anxiety disorders, and symptoms related to trauma and posttraumatic stress disorder. Significant work has been done in this area by Mark Reinecke and his colleagues at Northwestern University in the Clinical Psychology program in Chicago. Paula Barrett and her colleagues have also validated CBT as effective in a group setting for the treatment of youth and child anxiety using the Friends Program she authored. This CBT program has been recognized as best practice for the treatment of anxiety in children by the World Health Organization. CBT has been used with children and adolescents to treat a variety of conditions with good success. CBT is also used as a treatment modality for children who have experienced complex post-traumatic stress disorder and chronic maltreatment.

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Cognitive and Behavioral Therapies for children and adolescents usually are short-term treatments (i.e., often between 6-20 sessions) that focus on teaching young people and their parents specific skills. CBT is different from many other therapy approaches by focusing on the ways that a person's cognitions (i.e., thoughts), emotions, and behaviors are connected and how they affect one another. Because emotions, thoughts, and behaviors are all linked, CBT approaches allow for therapists to intervene at different points in the cycle. Though approaches can differ somewhat, they have the following in common :

The therapist and child or adolescent client develop goals for therapy together, often in close collaboration with parents, and track progress toward goals throughout the course of treatment.
The therapist and client work together with a mutual understanding that the therapist has theoretical and technical expertise, but the client is the expert on him- or herself.
The therapist seeks to help the client discover that he/she is powerful and capable of choosing positive thoughts and behaviors.
Treatment is often short-term. Clients actively participate in treatment in and out of session. Homework assignments often are included in therapy. The skills that are taught in these therapies require practice.
Treatment is goal-oriented to resolve present-day problems. Therapy involves working step-by-step to achieve goals.

Applied to stuttering

Cognitive behavioral therapy is increasingly being used to help people who stutter or stammer, to overcome anxiety. CBT teaches people to analyze how unhelpful thoughts may be contributing to their anxieties, which can cause avoidance behaviors, and further stuttering. People can then learn to challenge such thoughts. It can also be used to help people who stutter change negative beliefs about themselves into positive ones.

Such therapy can usually be obtained through speech and language therapists, trained in CBT. More recently, techniques offered by CBT are now available through computerized methods, including online approaches such as Speech Bloom, which is a study program for stuttering.

Complex trauma

Recent efforts have been made to develop models for using CBT with complex trauma. These models are still in their early stages but have strong promise. In particular programs based on the use of exposure therapy One example of a model being used is Cognitive Processing Therapy, which is used to treat post-traumatic stress disorder (PTSD) for veterans and sexual assault victims.

Research

Cognitive behavioral therapy most closely allies with the scientist-practitioner model, in which clinical practice and research is informed by a scientific perspective, clear operationalization of the problem, an emphasis on measurement (and measurable changes in cognition and behavior) and measurable goal-attainment.

Effective cognitive behavioral therapy is also dependent on a therapeutic alliance between the health care practitioner and the person seeking assistance. (See Therapeutic relationship)

Criticism

CBT has come under fire from non-CBT therapists who claim that the data does not fully support the extent of attention and funding it receives nor its extension beyond psychotherapy into matters such as reducing unemployment, and that the limitations of the CBT model when used to blanket-address psychological suffering are unrecognized. Psychotherapist and professor Andrew Samuels stated that this constitutes "a coup, a power play by a community that has suddenly found itself on the brink of corralling an enormous amount of money. Science isn't the appropriate perspective from which to look at emotional difficulties. Everyone has been seduced by CBT's apparent cheapness."

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Presenters at a psychotherapy conference at the University of East Anglia (UEA) in July 2008 criticized the increased spending on CBT and the widespread belief that CBT is more effective than other forms of psychotherapy. In this conference professors Mick Cooper and Robert Elliott (both at University of Strathclyde), William B Stiles (Miami University) and Art Bohart (Saybrook University) issued a joint statement, which briefly stated:

As more research focuses on CBT, more studies are published on CBT. This reinforces the logical error that CBT is superior and this has a direct negative effect on other forms of therapy, which are well documented but have smaller bodies of research.
People who get therapy improve substantially, regardless of the type of therapy they get. When therapies are compared to one another, they usually appear to be equally effective.
Excessive spending on CBT and discouraging other forms of therapy hurts the public.

At the same conference, professors Robert Elliott and Beth Freire presented their unpublished meta-analysis of more than 80 studies where person-centered psychotherapy was shown to be as effective as other forms of psychotherapy, including CBT.

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