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IN SESSION with Judith S. Beck, PhD

Cognitive-Behavioral Therapy

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What differentiates cognitive-behavioral therapy (CBT) from other therapies currently in use?

CBT is probably the most widely researched psychotherapy that exists today, and there is more research support for its efficacy than there is for any other therapy. The treatment is collaborative, structured, and goal-oriented. CBT is designed to be as short term as possible, though sometimes with complex cases and severe mental illness treatment takes longer. CBT also places a strong emphasis on relapse prevention, which essentially teaches patients skills so they can learn to be their own therapists.

How was CBT developed?

It was more of a revolution than an evolution, although CBT certainly has roots in various different psychotherapies. My father, Aaron T. Beck, MD, designed a series of experiments in the late 1950s and early 1960s to test the psychoanalytic concept that depression is hostility turned inward, and found that these experiments did not support this tenet. He then began to wonder if there was a different way to explain depression.

During this time, he began to realize that in addition to the thoughts patients revealed during free association, they often had another stream of thoughts that they did not report very often. For example, one patient spent a session regaling my father with her sexual exploits. At the end of the session, she said that she had felt very anxious during the session because she thought that my father had found her boring. This led to the idea that people can have two concurrent levels of thinking. In addition to a more volitional level of thinking, there is often an automatic level of thinking. That is, evaluative thoughts that spontaneously arise in people's minds.

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Upon inquiry, he found that other depressed patients reported the same type of stream of thought. In fact, when he began to examine his own and others' thinking, he found that everyone has this automatic level of thinking from time to time. He discovered that his depressed patients often had automatic thoughts that were highly negative and distorted. These patients tended to see themselves as failures, helpless, worthless, and unlovable.

Most patients are unaware of their automatic thoughts before they come to treatment. Frequently, they are more aware of the emotions or behavioral reactions that their automatic thoughts lead to. However, almost all patients can be easily taught to identify their automatic thoughts. At the Beck Institute, we explain to patients that when they are depressed it is almost as if they are wearing black glasses, so that everything that they see looks dark. We ask them to notice when their mood changes (or when they are engaging in dysfunctional behavior) and to ask themselves what is going through their minds. Then we teach patients to test the validity and utility of these thoughts. When they evaluate their thinking and see things more realistically, they feel better and are able to act more functionally. We also work directly on helping patients modify their dysfunctional behavior, and we may teach them emotional regulation techniques such as controlled breathing, relaxation exercises, and distraction.

Has CBT changed in any significant way since it was first started?

CBT has been expanded upon and elaborated since the very beginning. None of the initial assumptions or observations have been discarded, but therapy has become more specialized according to the type of disorder being treated. For example, it is important to understand that the cognitive formulation of depression is different from the cognitive formulation of other disorders. The key automatic thoughts in depression are negative cognitions about the self, the world, and the future. Such thoughts, however, are relatively less important to address in panic disorder, where therapists must focus on the catastrophic thoughts patients have about their symptoms. For example, a patient with panic disorder might believe that the increase in his heart rate and chest pain he is experiencing means he is about to have a heart attack. One of the ways that CBT has been elaborated and expanded upon has been the development of a cognitive formulation for each of the different disorders, as well as the development of specific techniques for each disorder. Therapists must determine the key cognitions and behaviors of each individual patient and use their conceptualization to plan treatment.

What defines a cognitive-behavioral therapist?

The Academy of Cognitive Therapy[5] was started approximately 7 years ago to answer just this question. Thirty-six leading cognitive-behavioral therapists from across the country decided to establish an organization that, among other important tasks, would set standards to certify mental health professionals as cognitive-behavioral therapists. In order to meet its requirements, clinicians must demonstrate that they have a certain amount of prior training and completed a number of cases using CBT. Therapists must also submit work samples, including case write-ups and therapy tapes, to demonstrate that they are really conceptualizing patients according the cognitive model and doing competent CBT. One reason for developing the Academy of Cognitive Therapy is that while many mental health professionals may self-identify as cognitive-behavioral therapists, many do not implement its most basic elements.

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The Beck Institute Web site[6] provides information about these basic elements and a brochure that describes for patients what should happen during treatment. At the very least, cognitive-behavioral therapists follow a certain structure in session. They ask about the patient's mood; make a bridge between sessions; set a specific problem-solving–oriented agenda; work toward solving specific problems; collaboratively set homework assignments (so patients can make small changes in their thinking and behavior every day); and summarize and ask for feedback at the end of sessions. If therapists are not doing these very basic things, chances are they are not practicing standard CBT. Of course, it takes much more than just following the structure to practice CBT effectively. Researchers have found in the CBT studies that therapists who demonstrate higher competency (as measured by the Cognitive Therapy Rating Scale) have better outcomes with their patients than those who receive low scores.

What is a typical series of sessions like?

A patient with a straightforward case of anxiety or depression will most likely stay in therapy for approximately 6–12 sessions, starting with weekly sessions. If the patient is in crisis, initial sessions may occur more often. As patients start to feel better and use the tools they have learned, therapy may be spaced out to once every 2 weeks and then once every 3–4 weeks. Even after termination, patients schedule "booster sessions" to prevent relapse.

At our institute, before we start treatment we conduct a thorough evaluation of the patient. In addition to extensive history-taking and a diagnostic interview, we do a careful analysis of patients' current functioning, asking what they do on a typical day from wake until sleep; how often they see family and friends; and how they function at work, outside of work, and in their relationships.

In the first session we seek to establish a strong therapeutic alliance; educate patients about their diagnosis; explain the cognitive model; elicit expectations for treatment; socialize patients to treatment; and, most importantly, instill hope. One way to do so is by setting specific goals with patients at this first session. We ask pointed questions, such as, "How would you like to be different by the end of treatment?" "What do you want your life to look like?" We help the patient form very concrete behavioral goals, such as, "I would like to meet new people," "I would like to be able to concentrate better at work," "I would like to be able to manage my finances better," "I would like to get back into exercising," "I would like to be more assertive," or, "I would like to get a job." We work toward these goals at every session.

At each session we ask patients how they have been feeling compared to previous sessions. We also ask them to fill out certain objective tests, such as the Beck Depression Inventory. A mood check provides a very quick look at what the patient's symptoms are, and at what has and has not improved. This helps inform the patient and therapist about whether treatment is effective enough. It may also point out problems to be discussed during the session.

Next, we set an agenda with patients, asking them to name current problems they would like us to help them solve during the visit. However, before discussing these problems in detail, we need to find out if there are any other pressing problems or issues. We ask patients what happened between the previous visit and the current session that is important for the therapist to know. We also ask patients whether they anticipate that any other problems might arise before the next therapy session. Following this, we review what the patient did for homework, what he or she learned, and what he or she wants to continue doing this coming week.

Next, we prioritize the problems on the agenda, finding out what patients think is most important to work on given our limited time together. Then we discuss the first problem, and, in the context of solving this problem, teach the patient the necessary cognitive and behavioral skills. The homework assignment, which is collaboratively set, naturally follows from this problem-solving process. It usually includes implementing solutions to problems and practicing skills. At the end of sessions we summarize or have patients summarize the most important learnings from the session, and we make sure they have these written down to review during the week. We also ask for feedback to find out how the patient felt about the session, whether the patient thinks we understood them correctly, and whether they want to do anything differently in the next session.

How do cognitive-behavioral therapists plan treatment?

Cognitive-behavioral therapists take the data that the patient presents, conceptualizes the patient in cognitive terms, and tailors treatment to the individual based on this conceptualization and on the cognitive formulation of the patient's disorder(s). The therapist seeks reasons for why the patient is experiencing his or her current difficulties, paying particular attention to the patient's perceptions of current situations that may lead to distress and/or dysfunctional behavior. The therapist also recognizes themes behind these ideas and works on patients' basic understandings about themselves, their worlds, and other people.

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An example is a depressed woman who spends a great deal of time inactive at home, just watching television. Because her mood is very low at these points, the therapist helps her identify what she is thinking as she is sitting on the couch watching TV. Typical automatic thoughts include, "I am such a failure. I don't have a job. I am so tired. I can't get off this couch. My life is terrible," and so forth. We then help the patient understand the connection between these thoughts and her emotions and behavior. We also look for the beliefs that give rise to these thoughts. In this example, it sounds as if the patient probably sees herself both as a failure and as helpless. The therapist then helps the patient evaluate these ideas and respond to them in an adaptive way. As a result, patients are able to take a different perspective on their difficulties and feel better. We would also work with this patient in scheduling activities, helping her to become more behaviorally activated as well as to solve her other problems.

Are there any particular disorders or symptoms that benefit most from CBT?

There have been approximately 400 outcome trials demonstrating that CBT is effective for a whole range of psychiatric disorders as well as for medical disorders with psychological components. While CBT is particularly effective for anxiety disorders and depression, it is also quite effective for a number of other disorders. It is important to note that while CBT is relatively equal in efficacy compared to medication for disorders like depression, it is twice as effective in preventing relapse.

Clinically, I have seen that when patients have comorbidity, strong personality disorders, or complex problems, treatment may take longer. This does not mean that the patient will not respond well, but rather that the patient might have a slower response rate. CBT has also been shown to be an effective treatment in addition to medication for chronic mental illnesses such as bipolar disorder and schizophrenia.

Should patients undergoing CBT take medication for the disorders that are being treated?

Usually, it is a collaborative decision between a prescribing physician and the patient as to whether or not the patient should use medication. If patients are uncertain and want help making a decision, therapists can advise them to do certain things such as get more information from their primary care physician, list and evaluate the advantages and disadvantages of medication, and evaluate their automatic thoughts about taking medication.

How does a therapist work with a patient who cannot participate or function within the structure of CBT?

It is very important for a cognitive-behavioral therapist to adapt the session to the patient. There are some patients who cannot tolerate the structure initially, or for whom the structure is really inappropriate. In such cases, the therapist must modify the treatment, at least initially. Some patients are accustomed to more traditional psychotherapy in which they speak about whatever is on their minds, without much direction from the therapist. Sometimes cognitive-behavioral therapists simply need to explain the rationale for structuring the session and to ask patients if this sounds okay. Difficulties in structuring the session can often be solved in a common-sense manner. For example, therapists may negotiate with patients, offering them the option of dividing the session so that they spend some time problem-solving and some time having the patient talk in an open-ended way without interruption.

How does a therapist work with resistant patients?

Whenever therapists find that patients are "resistant," they need to define the resistance in behavioral terms. For example, the patient may not do homework; not let the therapist get a word in edgewise; avoid talking about important problems; or continue to abuse substances. It is then important to determine whether therapists need to do practical problem solving, and/or help patients respond to interfering cognitions, and/or teach the patient new skills. One patient might not do homework because the therapist had suggested something that was much too difficult. In this case, it was really the therapist's error. The therapist must simply apologize and ensure that new assignments are appropriate. Another patient might not do homework because he thinks he will not do it well. In this case, the therapist needs to help the patient assess and decatastrophize this possibility.

What if the patient is in another kind of psychotherapy?

My colleagues and I have found that many patients do better if they are focused just on CBT. However, we always strive to be collaborative with the patient. Many patients are willing to take a hiatus from their other psychotherapy and give CBT a try for a few weeks. However, if the patient is unwilling to do so, CBT can be done in conjunction with another psychotherapy. The CBT therapist makes sure to contact the other therapist to coordinate efforts. ***PP***

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