Cognitive-Behavioral Therapy
It's not what you think

Bruce S. Liese, PhD, ABPP

APA Division 50 (Addictions)

Society for Addiction Psychology (SoAP)

January 8, 2016

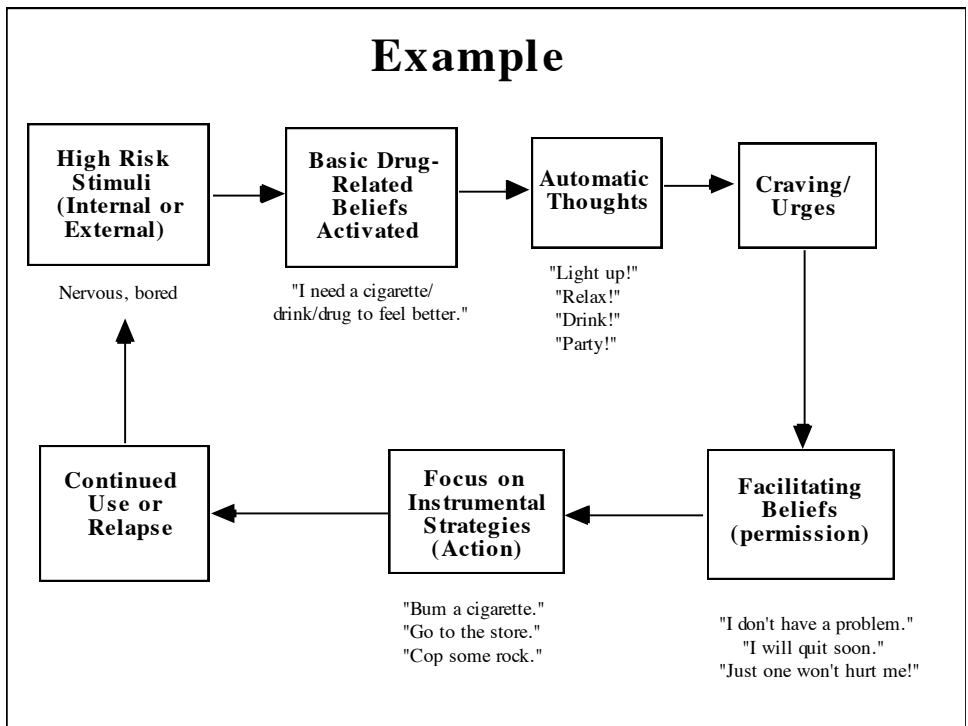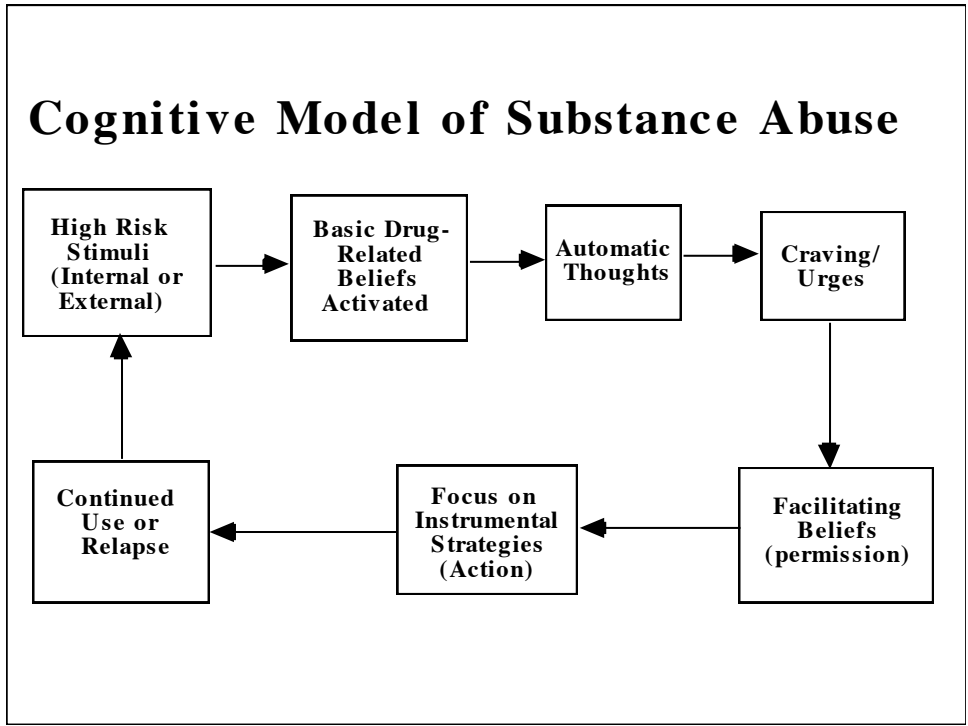# A Brief History of Cognitive-Behavioral Therapy

- Back in the 1970s, CBT focused first on more acute problems (e.g., depression)
- Later to anxiety
- Marital problems
- Personality disorders
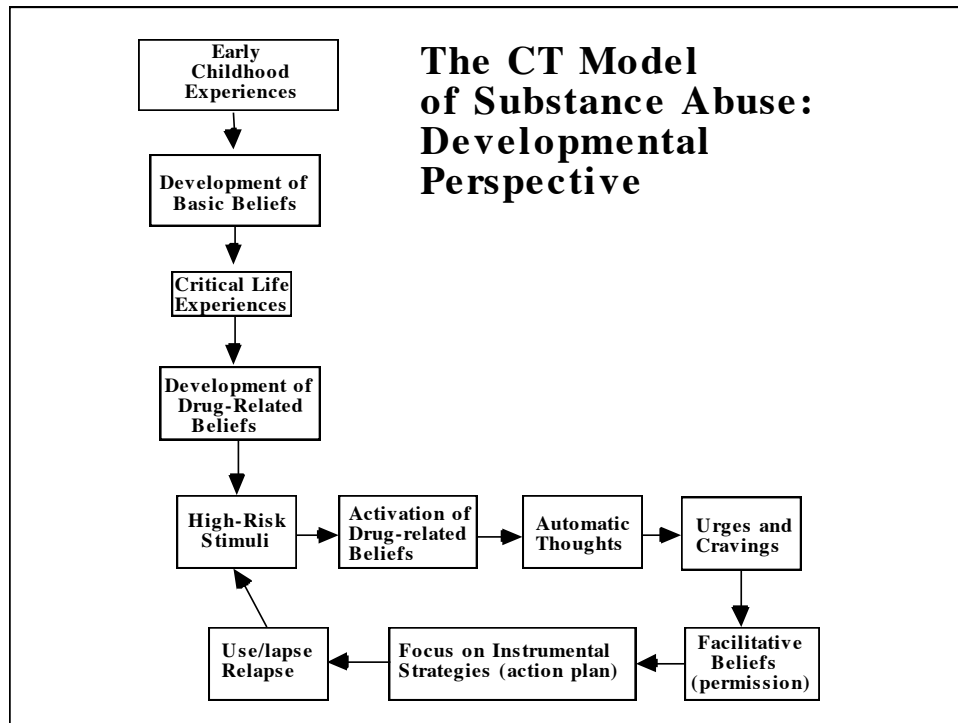- Severe psychiatric problems
- Substance abuse

CBT: Model of Depression

- Pervasive negative views of self, personal world, others, future
- Schemas: unlovable, inadequate
- Automatic thoughts: "I suck." "F__k it!" "I'm such a loser." "I'm just fat and ugly."
- Cognitive distortions

Cognitive Distortions

- All-or-none thinking
- Overgeneralizations
- Minimizing
- Shoulds and musts
- Labeling
- Emotional reasoning
- Selective abstracting

Cognitive Model of Substance Abuse

High Risk Stimuli (Internal or External) → Basic Drug-Related Beliefs Activated → Automatic Thoughts → Craving/Urges

Craving/Urges → Facilitating Beliefs (permission) → Focus on Instrumental Strategies (Action) → Continued Use or Relapse → High Risk Stimuli (Internal or External)

Example

High Risk Stimuli (Internal or External) → Basic Drug-Related Beliefs Activated → Automatic Thoughts → Craving/Urges

Nervous, bored

"I need a cigarette/ drink/drug to feel better."

"Light up!"
"Relax!"
"Drink!"
"Party!"

Craving/Urges → Facilitating Beliefs (permission) → Focus on Instrumental Strategies (Action) → Continued Use or Relapse → High Risk Stimuli

"Bum a cigarette."
"Go to the store."
"Cop some rock."

"I don't have a problem."
"I will quit soon."
"Just one won't hurt me!"

The CT Model of Substance Abuse: Developmental Perspective

Early Childhood Experiences → Development of Basic Beliefs → Critical Life Experiences → Development of Drug-Related Beliefs → High-Risk Stimuli → Activation of Drug-related Beliefs → Automatic Thoughts → Urges and Cravings → Facilitative Beliefs (permission) → Focus on Instrumental Strategies (action plan) → Use/lapse Relapse → High-Risk Stimuli

Important Refinements to Cognitive-Behavioral Therapy

- Emphasis has shifted from the application of techniques to conceptualization of patients

- "Therapist as teacher" is less important than "Therapist as ally, collaborator"

- "Short-term" treatment may be unrealistic, especially with a chronic condition like addictive behaviors

Lessons Learned...

The treatment of increasingly complex problems has taught us that:

- We needed to increase attention to the "basics" of good psychotherapy, and;

- We needed to come up with more sophisticated therapeutic processes.

Misconceptions of CBT
(Gluhoski, 1994)

- CBT ignores interpersonal relationship factors.

- CBT minimizes the therapeutic relationship.

- CBT ignores motivational issues.
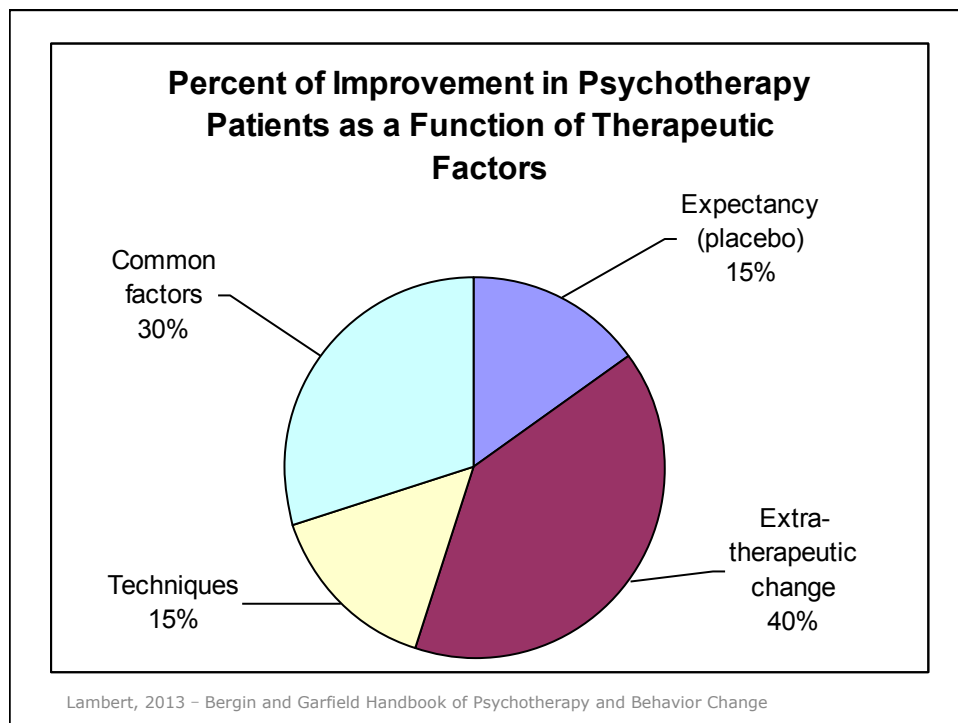
- CBT disregards emotion.

Misconceptions of CBT
(Gluhoski, 1994)

- CBT is superficial and mechanistic.
- CBT focuses on symptom reduction, ignoring personality reorganization.
- CBT ignores the importance of early life experiences.

According to A. T. Beck et al. (1979):

"Cognitive-behavioral techniques often seem deceptively simple. Consequently the neophyte therapist may become gimmick-oriented, ignoring the human aspects of the therapist-patient interaction. He [or she] may relate to the patient as one computer to another rather than as one person to another...

Beck et al. (con't)

...Some younger therapists, skilled in applying specific techniques, are perceived by patients as mechanical, manipulative, and more interested in the techniques than in the patient. It is important that techniques are applied in a tactful, therapeutic, and human manner by a fallible person--the therapist (p. 46)."

Percent of Improvement in Psychotherapy Patients as a Function of Therapeutic Factors

Expectancy (placebo) 15%

Common factors 30%

Extra-therapeutic change 40%

Techniques 15%

Lambert, 2013 – Bergin and Garfield Handbook of Psychotherapy and Behavior Change

Common Factors (30%)

- Common factors are the ingredients of psychotherapy that are advocated by most models.
- The most popular, well-studied common factors are those originally proposed by Carl Rogers and other humanistic psychologists: empathy, warmth, unconditional positive regard, caring.

Common Factors (con't)

- Catharsis
- Identification with the therapist
- Mitigation of isolation
- Positive relationship
- Reassurance
- Release of tension

Common Factors (con't)

- Structure
- Therapeutic alliance
- Therapist-client active participation
- Therapist expertness
- Warmth, empathy, trust, acceptance, genuineness, respect

The Five Components of all Effective Psychotherapies

- Structure
- Collaboration (the "Alliance")
- Case Conceptualization
- Socialization, Psychoeducation
- Techniques

Towards the Development of a Collaborative Relationship

- Warmth
- Genuineness
- Unconditional Positive Regard
- Accurate Empathy
- Leading to a rock-solid case conceptualization

Attending Skills

- Eye contact
- Body language
- Vocal qualities
- Verbal following

Basic Listening Sequence

- Ask open-ended questions
- Encourage responses
- Paraphrase
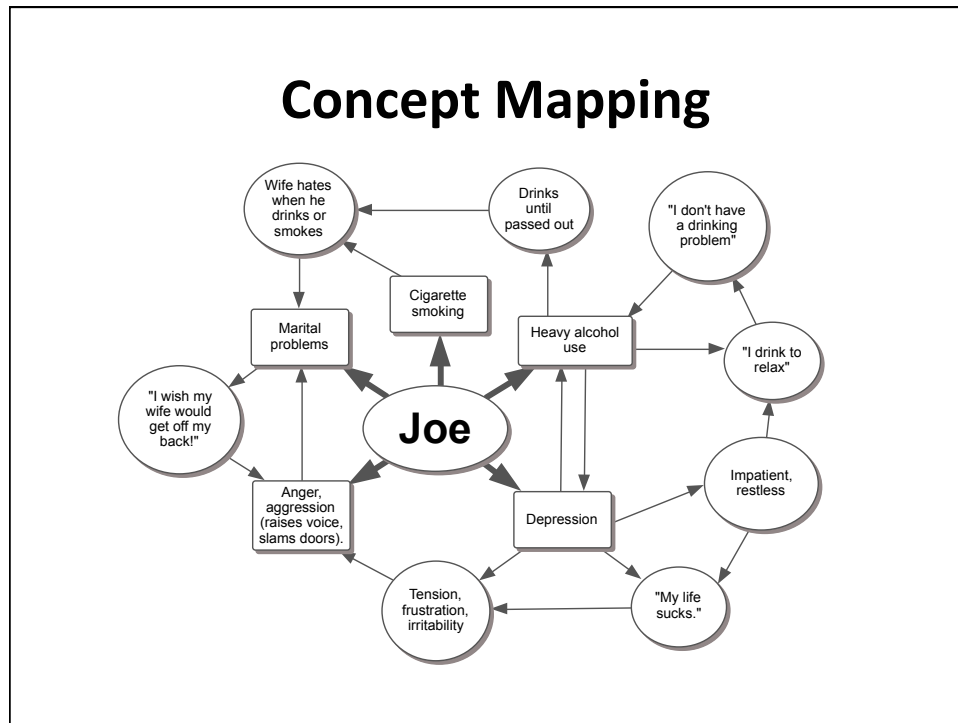- Reflect feelings/thoughts
- Summarize

Guided Discovery

A process of inquiry

that guides people to

Discover <u>their own answers</u>

to important questions.

Case Conceptualization

- Demographics (the "obvious" stuff)
- Psychiatric diagnoses
- Presenting problems and functioning
- Predominant thoughts, beliefs, etc.
- Long-standing compensatory and coping strategies
- Motivation to change
- Behavioral observations (in vivo)
- Integration (e.g., concept mapping)

Problem Grid

Problem	Behaviors	Feelings	Thoughts
Depression	• Withdraw from wife, other family members, and friends. • Withdraw from hobbies, social, and recreational activities.	• Impatient • Restless • Unhappy • Tense	• "My life sucks." • "Nothing works out." • "I'm tired of this."
Anger, Aggression	• Become visibly angry. • Raise voice. • Slam doors.	• Annoyed • Frustrated • Angry	• "Sometimes I just need to blow off steam." • "People piss me off."
Heavy alcohol use	• Drink alcohol and pass out every night while watching television.	• Tense until drinking begins • Relief after first drink	• "I don't have a drinking problem." • "I drink to relax."
Cigarette smoking	• Continue to smoke 2 packs of cigarettes per day, despite the fact that wife has asked him to stop on many occasions.	• Urges and cravings prior to smoking • Relief while smoking and for some time afterwards	• "I wish people would just get off my back about smoking." • "I'll quit when I'm good and ready."
Marital problems	• Anger, aggression towards wife. • Raise voice at wife. • Refuse to stop drinking, smoking.	• Angry that his wife is critical of him • Furious when wife threatens to leave	• "My marriage sucks." • "My wife is always on me about something." • "My wife doesn't understand me."

Concept Mapping

Techniques

Structured methods
(i.e., strategies)
for helping people.

Please do not copy or distribute without
permission of Bruce Liese, PhD
(bliese@kumc.edu)   13

Three-Question Technique

After maladaptive beliefs are identified, the three-question technique may be used to challenge these beliefs:

(1) What is your evidence?

(2) How else can you look at it?

(3) If your belief is true, what are the implications?

Ten Good Questions

- What do you think about that?

- What does that mean to you?

- What goes through your head?

- How do you understand that?

- What beliefs are triggered when that happens?

Ten Good Questions

- If its true, what would that mean?

- What are your basic beliefs about yourself? Your personal world? Other people? Your future?

- How do you explain that?

- What are advantages & disadvantages?

- What do you think of this therapy? Our relationship?

The Cognitive-Behavioral Therapy Adherence and Competence Scale

- Developed by Liese, Barber, & Beck (1995) for the NIDA Cocaine Treatment Study

- Supervisors rate therapists on 25 items; 7-point scale (0=poor; 6=excellent)

- 4 subscales: structure, collaboration, conceptualization, techniques

Items of the CTACS

CBT STRUCTURE

1. **<u>Agenda</u>** -- The therapist set an excellent, comprehensive, agenda; identified important target problems; prioritized and followed agenda.

2. **<u>Mood Check</u>** -- Did an excellent job of asking about mood; followed up with clarification; put important mood-related concerns on agenda; addressed concerns.

Items of the CTACS

3. **<u>Bridge from previous visit</u>** -- Discussed previous session with patient; emphasized important issues; related previous session to present agenda items; added unresolved issues to present agenda.

4. **<u>Status of current problems</u>** -- Asked excellent questions about primary problem and then followed up with appropriate responses and interventions.

Items of the CTACS

5. **Reviewing previous homework** -- Thoroughly reviewed previous homework or discussed incomplete homework.

6. **Assigning homework** -- Collaboratively assigned excellent, detailed homework; discussed fully with patient and began to plan and practice homework in the session.

Items of the CTACS

7. **Capsule summaries** -- Reliably and accurately provided excellent capsule summaries which were meaningful to the patient; therapist checked capsule summaries for accuracy and revised when appropriate.

8. **Patient summary and feedback** -- Asked for summary and feedback throughout the session; responded in a positive, supportive manner; appropriately adjusted behaviors based on the patient's feedback.

Items of the CTACS

9. **Focus/structure** -- Used time extremely effectively by directing the flow of conversation and redirecting when necessary; session seemed well paced, focused, and structured.

Items of the CTACS

COLLABORATIVE THERAPEUTIC RELATIONSHIP

10. **Socialization to cognitive therapy model** -- Did an outstanding job of describing relevant model, concepts, process, structure; applied these to patient in a timely manner; checked the patient's understanding and elicited feedback.

11. **Warmth/genuineness/congruence** -- Appeared optimally warm, genuine, caring, and congruent.

Positive Items of the CTACS

12. **Acceptance/respect** -- Appeared fully accepting, respectful, nonjudgemental.*

13. **Attentiveness** -- Was extremely attentive to important obvious and subtle cues.*

14. **Accurate empathy** -- Demonstrated excellent empathy skills and insight; shared insights.*

15. **Collaboration** -- Extremely collaborative; shared responsibility for defining problems and potential solutions; functioned as a team.

Items of the CTACS

THE CASE CONCEPTUALIZATION

16. **Eliciting automatic thoughts** -- Excellent job of eliciting AT's; effectively related these to patient's problems.

17. **Eliciting core beliefs and schemas** -- Excellent job of eliciting core beliefs/ schemas; effectively related these to patient's problems.

Items of the CTACS

18. **Eliciting meaning/understanding/ attributions** -- Excellent job of asking for meaning of salient events and beliefs; followed up very appropriately and substantially.

19. **Addressing key issues** -- Raised important and salient key issues (e.g., adaptability, autonomy, commitment, integrity, intimacy, responsibility, spirituality, spontaneity); related to schemas, beliefs, automatic thoughts, emotions, behaviors.

Items of the CTACS

20. **Case conceptualization: Linking past to present** -- Inquired about developmental processes when appropriate; linked accurately to current beliefs, thoughts, emotions, behaviors; elicited feedback regarding accuracy and usefulness.

21. **Sharing the conceptualization with the patient** -- Provided the patient with an excellent, thorough conceptualization of problems; elicited feedback regarding accuracy and usefulness.*

Positive Items of the CTACS

COGNITIVE & BEHAVIORAL TECHNIQUES

22. **Guided discovery** -- Very skillfully used a balance of open-ended questions, reflective, confrontive, and interpretive responses to guide patient's understanding of important issues.

23. **Asking for evidence/alternative views** -- Asked in a very timely and effective manner, for evidence for maladaptive beliefs, alternative views; appropriately followed up.

Positive Items of the CTACS

24. **Use of alternative cognitive and behavioral techniques** -- Did an outstanding job of selecting and applying standardized methods.

25. **Overall performance** -- Performance in this session is excellent; CBT practiced at a level equal to or superior to supervisor's level of proficiency; knows the relevant treatment manual extremely well; applies the case formulation with ease and flexibility; represents "state of the art" CBT.

Lessons Learned

1. Have a full understanding of the problems you treat and the extra-therapeutic resources available for treating them.

2. Understand compensatory strategies

3. Master collaboration and alliance formation

4. Expect and repair ruptures

5. Look for competing hypotheses (e.g., co-existing disorders)

More Lessons Learned

6. Maintain a developmental perspective

7. Use confrontation effectively

8. Stay focused

9. Use techniques appropriately and sparingly

10. Don't let the pace of change or relapse get to you