CBT goes beyond behaviourist models

Mental health

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Aaron Beck developed cognitive behavioural therapy (CBT) in the late 1960s, although none of the ideas were novel. In 300BC the Greek philosopher Epiticus articulated the CBT concept that our thoughts affect our attitude and behaviour toward situations. Other early philosophers and psychologists, including Nietzsche, Jung and Freud, also explained human behaviour in terms of the way we think.

Before Beck introduced CBT, Pavlov and Skinner's behaviourist theories dominated post-war psychology. These theories, which postulated all behaviour could be explained as simple stimulus-response programmes, dominated psychological explanations of attitudes and thinking with the concept of conditioned response. Explaining and changing behaviour in behaviourist terms involved a process of rewarding desired behaviour (or withdrawing reinforcement), or negatively reinforcing or punishing undesired behaviour. The extremes of behavioural theory were the *Clockwork Orange* type of electro-aversive therapy for sociopathic behaviours.

We all respond differently

Beck argued we were not simple stimulus-response processors, but would all respond differently to a stimulus based on the meaning, or cognitions, we attached to it. Furthermore, everyone's cognitive map had differences, so each person would interpret the same situation differently. Each person would also have different physiological, emotional and behavioural responses, based on their cognitive appraisal of the situation (which is shown in Figure 1).

This is possibly best illustrated by the Jewish psychiatrist, Viktor Frankl, in his book *Man's search for meaning*, his personal account of surviving the horrors of Nazi concentration camps. He was curious why people had such different emotional, physiological and behavioural responses to the same shared experience. He concluded the meaning, or cognitions, each person attached to their experience most influenced their outcome.

Frankl concluded about himself there was nothing wrong with being Jewish. He also believed strongly the Nazis were committing crimes which others, whom he considered to be "good", would hold them accountable for and when this suffering was over he would have to reunite his wife, children and parents again in the real world. The question, he stated, was not what he expected from life, but what life expected from him. He concluded his responsibility was to conduct himself with dignity and respect and to not let the Nazis define him in any way. His cognitive map, or the filter through which he interpreted his experience, allowed him to problem solve and respond to his suffering in an adaptive way.

Toxic early childhood experiences, particularly those that undermined self-esteem, form into an unhelpful cognitive map

Cognitions are the automatic thoughts, underlying assumptions and core beliefs we form about ourselves, others, the future and the world – they have variously been described as templates, schema, self-talk, internal dialogue or maps. Particularly where they become counter-productive (eg, excessive worry, obsessive rumination, "catastrophising" worst-case scenarios, hopelessness or helplessness), cognitions can cause complicating cognitive issues of thought-blocking, poor concentration and short-term memory loss, leading to poor problem-solving and a sense of being stuck.

Cognitions form, like layers of an onion, to include all our automatic thoughts, judgements and conclusions. They solidify into a deeper level of underlying assumptions we hold about ourselves, other people and our future and these set into the deeply held core beliefs we consider indisputable "truths" (shown in Figure 2).

Toxic early childhood experiences, particularly those that undermined self-esteem, or threatened our safety, form into an unhelpful cognitive map. Further negative events then typically reinforce the negative cognitions formed in our early development, perpetuating them or "proving" them correct. Our conclusions about these events confirm the core belief until it becomes a truth beyond enquiry.

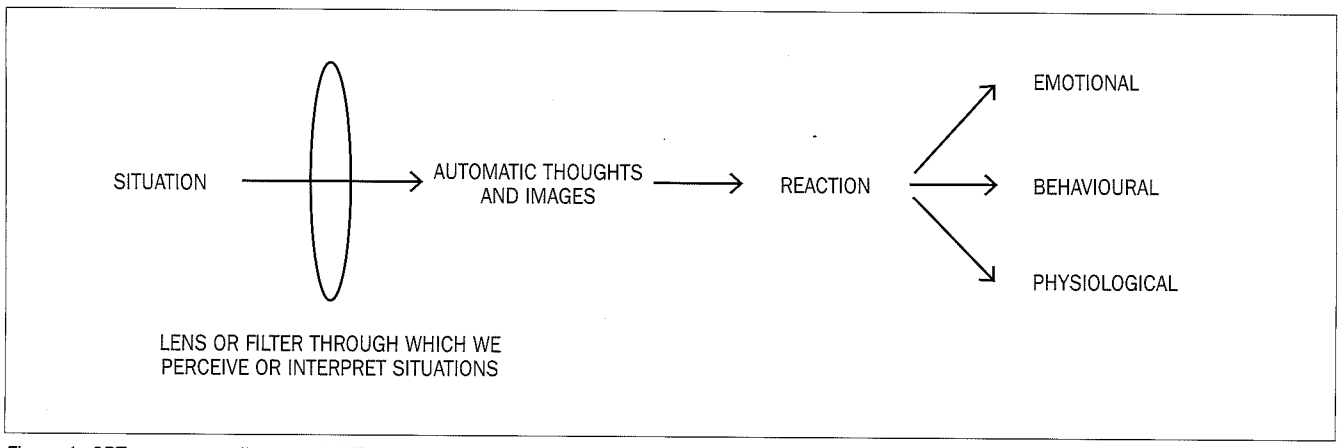

Figure 1. CBT argues we all respond differently, based on the lens through which we interpret a stimulus

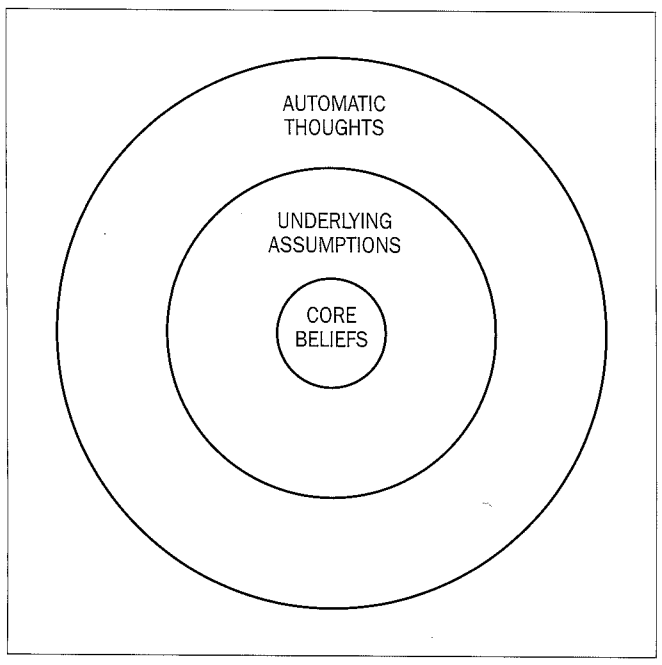

Figure 2. Our automatic thoughts solidify into underlying assumptions and deeply held core beliefs

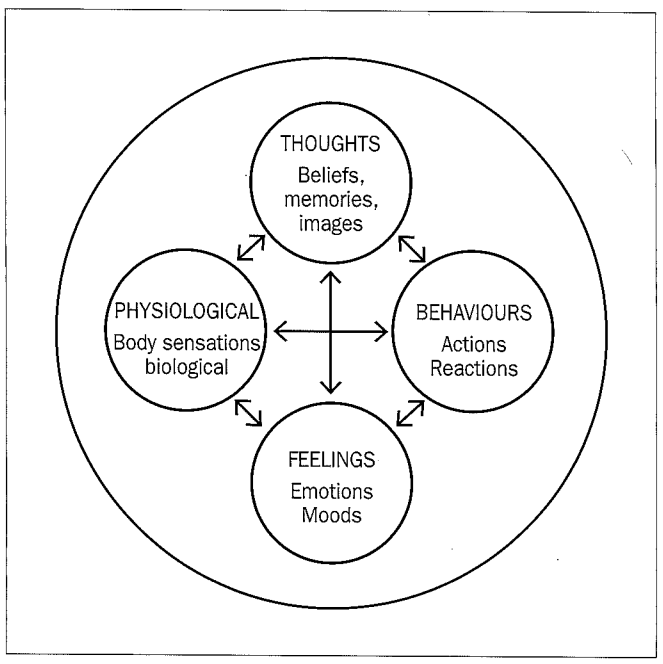

Figure 3. The CBT five-part model separates thoughts, behaviours, feelings and physiological responses, and the backdrop against which they exist

Key points

- Cognitive behavioural therapy is based on the belief we are not simple stimulus-response processors, but all respond differently to a stimulus.
- The "cognitions" we filter stimuli through include automatic thoughts, underlying assumptions and core beliefs.
- CBT helps identify these cognitions, explain how they are often unrealistic or unhelpful and offer alternative explanations.
- CBT is an evidence-based therapy, with a structure and an empirically tested model.

Suggested reading

Greenberger D and Padesky C. *Mind Over Mood: Change how you feel by changing the way you think*. New York: Guilford Press; 1995.

Identifying assumptions and core beliefs

CBT helps the person identify these cognitions and explains how they are often unrealistic or unhelpful distortions and then tries to offer alternative explanations from objective evidence that will help the person to a more helpful and balanced opinion about themselves, others, their future and the world.

CBT is a therapy, but it is also a very useful explanatory model for reducing any mental health condition into its components. For someone with a mental health condition, it is often a confusing and distressing mixture with no explanation and, therefore, no solution.

The CBT formulation is defined as the five-part model (see Figure 3). These five parts are, in reality, interwoven, but for explanatory purposes we separate them as discreet categories. This allows a person's symptoms to be understood and more easily managed.

The first part of the model is a backdrop against which the physiological, behavioural, emotional and cognitive symptoms exist. This consists of predisposing and perpetuating environmental factors – childhood events, physical injury, death of loved ones, history of trauma, chronic illness, employment issues, substance abuse history, etc. Most adjustment disorder issues can be explained by identifying the life events that precipitated them as they appear.

It then focuses on the four aspects the person with the mood disorder typically presents with in the here and now:

- physiological or body responses, eg, insomnia/hypersomnia, changed appetite, heaviness/lethargy, fatigue/tiredness, physical/somatic symptoms, low libido, hyperventilation, agitation, panic symptoms
- behaviours or actions, eg, social withdrawal, avoidance, anhedonia/loss of pleasure, amotivation, reduced self-care, increased substance use, crying, perfectionism, control
- emotions or mood, eg, mad (angry, irritable, enraged), bad (guilty, ashamed, disrespected), sad (depressed, maudlin, melancholy, blue, down), or scared (anxious, nervous, worried, paranoid, suspicious)
- cognitions, which include our automatic thoughts, underlying assumptions and core beliefs about ourselves, others, our future and our world.

CBT is an evidence-based therapy, with a structure and an empirically tested model. While each therapist applies the therapy differently, the outcomes are typically similar if the therapist adheres to the model. This makes CBT particularly applicable to managed-care, or brief therapy services.

Research and clinical trials have consistently shown that, for many mental health conditions, in particular anxiety and depression, selective serotonin-reuptake inhibitors combined with CBT, predict better outcomes in terms of reduced symptoms, time to normal functioning and time to and severity of future relapse of symptoms, than only one of those treatments alone.

In my next two articles, I will elaborate using CBT for depression and anxiety. I will give tips on stabilising physiological symptoms, behavioural interventions and mood management strategies health practitioners can use, and the cognitive restructuring trained CBT practitioners typically conduct. I will also discuss the growing use of e-CBT, which new research asserts is as effective as, if not better than, face-to-face CBT therapy.

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