



# An introduction to providing cognitive behavioural therapy

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**ABSTRACT** Davies-Smith, L. (2006) An introduction to providing cognitive behavioural therapy. *Nursing Times*; 102, 26: 28–30.

This article outlines the theory underpinning the practice of cognitive behavioural therapy (CBT) and some of the intervention techniques commonly used by CBT psychotherapists. It also looks at government publications relating to the provision of psychotherapies in the NHS and training requirements for different levels of CBT psychotherapy and practice.

Cognitive behavioural therapy (CBT) is named in the Department of Health (2001) publication *Treatment Choice in Psychological Therapies and Counselling: Evidence-based Clinical Practice Guideline* as one of the major formal psychotherapies commonly practised in the NHS (along with systemic and psychoanalytic). The same document found evidence supporting the provision of CBT for post-traumatic stress, depressive disorders, anxiety disorders, bulimia, chronic fatigue and chronic pain. A recent DH (2004) report stated that 'psychological therapies are fundamental to basic mental health care'.

### CBT overview

CBT is a synthesis of behaviour therapy and cognitive therapy. Behaviour therapy is based on the idea that all behaviour, normal and abnormal, is acquired and maintained in identical ways – that is in accordance

with the principles of learning theory, in which the role of classical conditioning (Pavlov, 1927) and operant conditioning (Skinner, 1953; 1938) are seen as primary. Behaviour disorders are viewed as learnt maladaptive patterns and not as symptoms of a presumed underlying cause, as in a psychoanalytical or psychodynamic model. If behaviour is action – what one does – then cognitions are one's mental processes, through which one thinks about and ascribes meaning to oneself, others and events, and from which one develops beliefs, attitudes and expectations. The link between what one thinks and what one believes is important. CBT theory holds that core beliefs are the tacit beliefs people have about themselves and the world they inhabit.

Cognitive therapy grew out of the work of Beck (1967) who published a psychological model of depression suggesting that thoughts play a significant role in the development and maintenance of depression. Beck identified patterns of thinking that correlated with symptoms of depression, thereby establishing a link between what one thinks and how one feels.

He is known for carrying out much of the initial research on the theory that distorted or inaccurate thoughts are a precursor in the development and maintenance of depression, and other emotional disorders, and the development of the cognitive treatment approach.

To complete the picture, one must include physiological changes that occur in response to thoughts, behaviour and emotion. As an example consider the 'fight or flight response' when one thinks there is impending danger. The adrenal glands release adrenaline into the bloodstream, the heart beats faster, blood is pumped to major muscles and the liver releases glucose into the bloodstream, ensuring the body is more able to defend or flee as appropriate.

Fig 1 shows the reciprocal relationships between behaviour, feelings, physiology and thoughts, with all stimulating and responding to each other.

Beck invented the term 'automatic thoughts' to describe reflexive, negative thoughts, which spring to mind and create an emotional affect, such as anxiety, which in turn affects a physiological response, such as fight or flight, and a behavioural response, such as avoiding anxiety-provoking situations.

CBT uses techniques to help people become more aware of how they reason and the kinds of automatic thoughts that spring to mind, as these automatic

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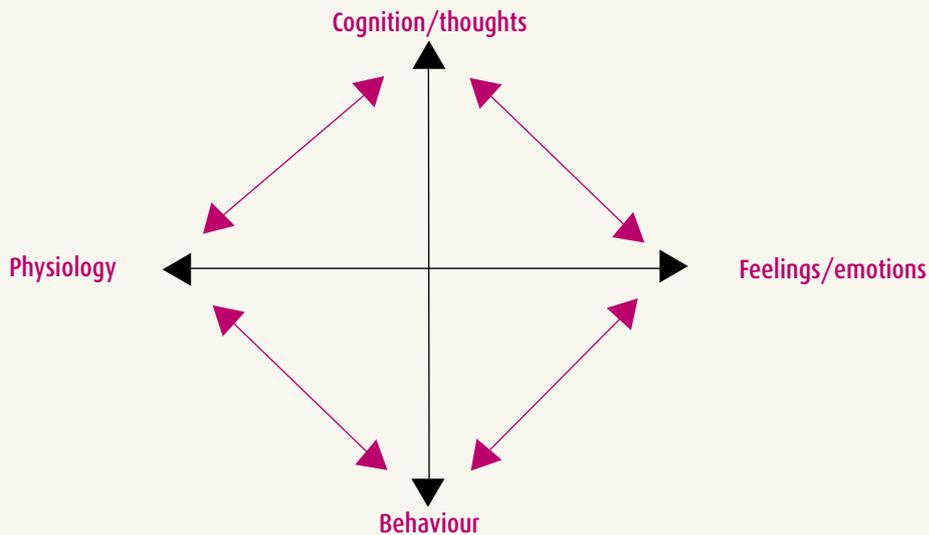
### Learning objectives



Each week *Nursing Times* publishes a guided learning article with reflection points to help you with your CPD. After reading the article you should be able to:

- Understand the theory behind cognitive behavioural therapy;
- Know some of the self-defeating thoughts that CBT seeks to address;
- Describe some of the interventions used in CBT;
- Know the kind of conditions that CBT can be used in.

**FIG 1. THE RECIPROCAL RELATIONSHIPS BETWEEN BEHAVIOUR, FEELINGS, PHYSIOLOGY AND THOUGHTS (WOOLFE AND DRYDEN, 1996)**



thoughts are often erroneous and self-defeating. These thoughts can be erroneous in their content, or in the way in which information is processed and differs depending on the clinical symptoms. For instance, patients with depression when compared with other clinical groups and controls are more negative about things (Hagga et al, 1991).

Depressed people also have impaired problem-solving skills (Nezu et al, 1989) and retrieve negative memories more easily and quickly than positive memories (Clarke and Teasdale, 1982). For those experiencing anxiety disorders, such as panic and phobias, common thinking themes are increased perception of danger and threat, alongside a belief in one's own lack of ability to cope with that danger (Beck and Emery, 1985).

Burns (1980) lists 10 common self-defeating thought processes:

- All or nothing thinking, for example, if I am not perfect I am a failure;
- Over-generalisation – where it is concluded from one negative event that other negative events are thereby likely, for example, I wasn't successful at that now everything will fall apart;
- Mental filter – filtering out the positive aspects of a situation and dwelling on a negative fragment, for example, going out with friends who arrived late, the evening was enjoyable but that is disregarded and their late arrival is ruminated on;
- Automatic discounting – a sensitivity to absorbing negative information and summarily discounting positive information, for example, yes I was given a compliment but he was nice to everyone;
- Jumping to conclusions – where a conclusion is inferred from irrelevant evidence, for example, my

friend has cancelled our trip to the cinema, she must have fallen out with me. This often involves 'mind reading', for example, my partner is fed up with me, and wants to leave me, and 'fortune telling' – jumping to conclusions about the future;

- Magnification and minimisation – magnifying imperfections and minimising positive attributes;
- Emotional reasoning – using feeling as evidence of the truth of a situation, for example, I feel guilty therefore I must have done something bad;
- Should statements – an overdose of moral imperatives, for example, 'shoulds', 'musts', 'have to's' and 'oughts';
- Labelling and mislabelling – emotional reactions are in large measure a product of the label a person attaches to a phenomenon. An inappropriate label can produce a distressing reaction;
- Personalisation – egocentric interpretation of interpersonal event relating to the self, for example, 'two people laughed as I walked by, probably because I look odd'.

### CBT intervention techniques

CBT intervenes at both the level of thinking by helping people to identify and then change 'faulty' automatic thoughts and the associated core beliefs that are contributing to distress. This is performed through behavioural tasks, many of which are given in the form of homework to be completed between the CBT sessions.

However, before initiating the CBT intervention techniques, the therapist must consider what Beck termed a 'therapeutic collaboration'. Beck (1976) states that: 'It is useful to conceive of the patient-therapist relationship as a joint effort. It is not the

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- This article has been double-blind peer-reviewed.
- For related articles on this subject and links to relevant websites see [www.nursingtimes.net](http://www.nursingtimes.net)

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therapist’s function to try to reform the patient; rather her or his role is working with the patient against “it” – the patient’s problem.’

Other components of a therapeutic collaboration are reaching a consensus regarding what problem requires help, the goal of therapy and how to reach that goal. The therapist and client are partners in the process of problem solving.

The majority of people who enter into therapy are unaware that what they think and how they interpret events influences their feelings and behaviour. The therapist will typically explain this concept and use it as a rationale to enlist clients in the task of joining with the therapist to identify their cognitive processes, automatic thoughts and unhelpful behaviours, thereby making them available for modification and cognitive restructuring.

Socratic questioning is a technique where the therapist asks questions to elicit answers, which are then questioned. The rationale being the original questions help expose thoughts and beliefs, a process known as guided discovery. Then the therapist asks further questions to explore the validity or otherwise of those thoughts and beliefs, the intention being to expose and modify any self-defeating cognitive processes.

Clients may agree to do a homework task. For example, someone with an alcohol dependency problem may agree to monitor and record cravings for alcohol and the situations and thoughts that precipitated the cravings. This is called self-monitoring. What the client discovers using the self-monitoring process is examined in subsequent sessions with the therapist using a method called reality testing. The client is taught to examine the evidence supporting or refuting the validity of the thoughts and beliefs. As flexibility in behaviour, thinking, explanations and perceived solutions has often disappeared, the therapist encourages clients to generate alternatives.

Other methods a therapist and client might jointly agree to use are:

- Activity scheduling – agreed activities plan to help clients spend less time ruminating;
- Rating scales – clients rate on a scale of 0–10. Ratings help to challenge ‘all or nothing’ thinking as they impose a continuum rather than a choice between, for example, enjoyable/not enjoyable;
- Positive self-talk – clients talk to themselves in positive terms. This interrupts the automatic negative thoughts and builds a more positive self-image;
- Role-play – to practise new behaviours and effect cognitive change;
- Cognitive and behavioural rehearsal – may be used in sessions and independently by clients to generate and practise new ways of thinking and behaving;
- Practical skills training – may be employed to help with difficulties such as communication, assertiveness or social skills;
- Relaxation techniques – may be taught to help manage the client’s anxiety responses, thereby promoting a feeling of mastery over symptoms and to promote self-awareness and monitoring of bodily states.

This is by no means an exhaustive list but gives a flavour of the CBT approach.

**The conditions where CBT is used**

Guidelines produced by NICE recommend that CBT be offered to those with a diagnosis of anxiety and panic disorder, depression, depression in children and young people, eating disorders, obsessive-compulsive disorder, post-traumatic stress disorder, self-harm and schizophrenia (NICE, 2005a; b; c; 2004a; b; c; d; 2002). In addition, CBT can be used for many other conditions, for instance, anger management and pain management.

**The nurse’s role**

The NHS Executive’s (1996) review of strategic policy for psychotherapy services advised that psychological therapies are an important part of mainstream NHS mental health care. It states that they are ‘one of the two main approaches to the treatment of the mentally ill’ (the other being physical treatments such as medication and electro-convulsive therapy).

Additionally, Agenda for Change emphasises, via appraisals and the Knowledge and Skills Framework, the benefits for both the employee and employer of lifelong learning and CPD.

These two conditions provide fertile circumstances for anyone who wishes to consider adding to their skill base. The demand for specialist nurse therapists who can provide psychological input is becoming more evident and will continue to grow in the foreseeable future. Some nurses choose to focus on a particular condition, for example, psychosis or eating disorders and learn CBT techniques relevant to that area, while others may choose to undertake full psychotherapy training. ■



**Guided reflection**

Use the following points to write a reflection for your PREP portfolio:

- Detail where you work and why this article is relevant;
- Outline the last time you encountered a patient who could have benefited from cognitive behavioural therapy;
- Describe a new piece of information you have learnt in this article;
- How could this new information have helped you in your area of work;
- Explain how you intend to disseminate this information.