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# Overview of Cognitive Behavioral Therapy

When an individual is initially diagnosed with a chronic illness or acquires a new impairment, a number of very realistic concerns and fears may rapidly come to mind. These include worry about physical pain (Will I be able to endure this pain?) overall quality of life (Will I ever be able to eat what I like again? How will this affect my sex life?), and mortality (Am I going to die?). There may be apprehensiveness about the perceptions and opinions of others (What will people think when they see I am wearing a wig?) and desirability to others (Who would want to marry me now?). There may be economic concern (How will I pay for all the medical expenses?) and questions about how the condition will this affect his or her involvement in daily activities, roles, and responsibilities (Will I be able to keep my job? What kind of a parent will I be?). An individual may also wonder how the condition will affect close friends, partners, or family members and worry about who will take care of dependent children or elders.

These are only a few of the many potential concerns that a person with a chronic condition might have. Cognitive behavioral therapy is an approach that can be used by psychotherapists and other medical and rehabilitation professionals to address such concerns. It can facilitate improved quality of life and adaptation for individuals with chronic conditions.

## What is Cognitive-Behavioral Therapy?

A variety of approaches to therapy are generally considered to fall within the broader domain of cognitive behavioral therapy (Dobson and Dozios, 2001). These approaches share three assumptions:

- Cognition affects behavior
- Cognition can be monitored and altered
- Behavior change is mediated by cognitive change

Cognitive behavioral therapy always involves cognitive mediation of behavior as the fundamental core of treatment.

According to Dobson, (2001), cognitive behavioral therapies can be grouped under three broad categories:

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- Coping skills methods
- Problem-solving methods
- Cognitive restructuring methods

These categories reflect differences in the degree of emphasis on cognitive versus behavioral change (Dobson and Dozios, 2001). A more comprehensive analysis of the nuanced differences between many approaches to cognitive behavioral therapy can be found in Dobson, (2001). This book reflects some degree of integration of all three of these approaches to cognitive behavioral therapy.

It is generally accepted that the different categories of therapy are best suited for different kinds of presenting problems (Dobson and Dozios, 2001). For example, the coping skills therapies are best applied to clients that are reacting to problems or situations occurring outside of themselves. These approaches focus on changing cognitions that serve to exacerbate the consequences of a negative event and on improving cognitive and behavioral approaches to coping with that event. Cognitive restructuring methods are best applied to problems emerging from within the psyche and thus require a more comprehensive and multilevel approach to cognitive change.

The theory and procedures of cognitive therapy (Beck, 1995; Beck, 1996) will be emphasized most centrally in this book. This approach emphasizes the way in which systematic errors in thinking and unrealistic cognitive appraisals of events can lead to negative emotions and maladaptive behaviors. Because this book also draws upon knowledge produced within the broader area of cognitive behavioral therapy, cognitive behavioral therapy will be the term that is used. Though at first glance cognitive behavioral approaches may be classified more narrowly as relying primarily on cognitive restructuring methods, recent applications to individuals with chronic conditions consider the necessity of working with realistic cognitions that occur as clients face adverse life circumstances (Moorey, 1996).

Cognitive behavioral therapy is a structured form of therapy guided by the cognitive model. The cognitive model proposes that dysfunctional thinking and unrealistic cognitive appraisals of certain life events can negatively influence feelings and behavior and that this process is reciprocal, generative of further cognitive impairment, and common to all psychological problems (Beck, 1985, 1991, 1995, 1999). Because this model will be emphasized and elaborated throughout the book, this chapter will limit itself to an overview of only the core concepts.

### Core Concepts

As shown in Figure 1, the core of Beck's (1991, 1995, 1999) cognitive model incorporates a hierarchy involving three levels of cognition:

- Core beliefs
- Intermediate beliefs
- Automatic thoughts and images

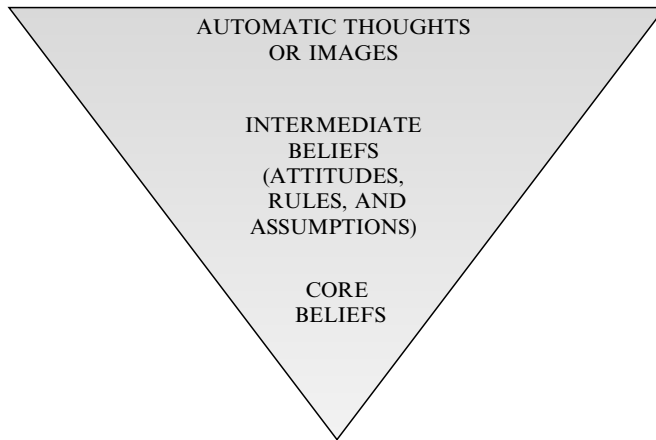


FIGURE 1. A Hierarchy of Three Levels of Cognition

Core beliefs are the most entrenched and inner level of beliefs. The core beliefs of well-adjusted individuals allow them to interpret, appraise, and respond to life events in realistic and adaptive ways. When dysfunctional, core beliefs represent distortions of reality and tend to be global, rigid, and overgeneralized (e.g., “I am a burden to others.”) (Beck, 1995).

Intermediate beliefs are defined as often unarticulated attitudes, rules, expectations, or assumptions (conditional statements). The following are examples of intermediate beliefs:

- “Sick people are a burden.”
- “No one wants to hear about another person’s medical problems.”
- “People get sick because they don’t take care of themselves.”
- “If I fail to follow any of my physician’s recommendations, I’ll be punished with a relapse.”
- “I will be an example of the worst prognosis of this disease.”
- “If I ignore my symptoms I won’t be such a burden to others.”

Importantly, intermediate beliefs influence an individual’s view of a situation, and ultimately, his or her thinking, feelings, and behavior.

Automatic thoughts are defined as the most superficial level of cognition. The following are examples of a negative automatic thought:

- “I won’t be able to get up today.”
- “Those people were offended by my appearance.”
- “That pain means I’m getting worse.”
- “I can tell they will be relieved when I’m gone.”

As the examples show, automatic thoughts are the actual sayings or images that go through one’s mind in a given situation.

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These three aspects of cognition are organized in terms of a hierarchy such that core beliefs drive intermediate beliefs and both ultimately manifest themselves in terms of automatic thoughts. Core beliefs serve to organize and process incoming information (Beck, 1991, 1996). Both core beliefs and intermediate beliefs arise as a result of people's attempts to interpret and make sense of their life experiences and environment. The way in which they approach this interpretation depends largely on the approaches to thinking they learned earlier in their development (Beck, 1995).

### The Goal of Cognitive Behavioral Therapy

The goal of cognitive behavioral therapy is to teach a client to replace distorted thinking and unrealistic cognitive appraisals with more realistic and adaptive appraisals. The initial stages of therapy involve educating clients about the relationships between situational triggers, automatic thoughts, and emotional, behavioral, and physiological reactions according to the cognitive model (Beck, 1995).

The initial stages of therapy also involve creating homework assignments, behavioral experiments and learning experiences that teach clients to identify, monitor, and evaluate the validity of automatic thoughts. This generally leads to a degree of symptom relief. The later stages of therapy involve identifying and modifying the intermediate and core beliefs that underlie the automatic thoughts, cut across situations, and predispose individuals to engage in dysfunctional thinking. The final stages of therapy focus on relapse prevention and on empowering the client to function as his or her own therapist. Judith Beck (1995) has outlined 10 general principles that define the cognitive behavioral approach. These are summarized in Table 1. These principles and the corresponding specific techniques of cognitive behavioral therapy as they apply more uniquely to individuals with chronic conditions will be elaborated in subsequent chapters.

### Why Cognitive Behavioral Therapy?

There are three general reasons why cognitive behavioral therapy is particularly useful for individuals with chronic conditions. These are that cognitive behavioral therapy

- Is useful for treating psychological symptoms that can accompany a chronic condition or become exacerbated as a result of stressors associated with the chronic experience of illness or impairment,
- Readily addresses the practical problems and unique challenges that clients with chronic conditions face, and
- Has substantial empirical support for its efficacy.

Each of these reasons is discussed below.

TABLE 1. Beck's general principles of cognitive behavioral therapy.

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- Therapists construct an ongoing case conceptualization based on the cognitive model and make revisions to that conceptualization as more information becomes available.
  - Therapists make multiple efforts to ensure a strong therapeutic relationship. This includes ongoing solicitation of feedback from the client about the relationship.
  - Therapists expect collaboration and active participation on the part of the client.
  - The therapeutic relationship is characterized by collaborative empiricism and guided discovery.
  - Therapists emphasize structured approaches to goal setting based upon the enumeration of specific problems.
  - In the initial stages of therapy, therapists emphasize problems occurring in present time.
  - Therapists educate clients about their conditions and about the cognitive model in order to promote self-treatment and prevent relapses.
  - Therapists and clients set goals regarding the overall length of treatment so that clients will bear in mind that treatment is generally time-limited.
  - Therapists ensure that sessions are structured and that they include a specific agenda.
  - Clients learn to identify, evaluate, and respond to dysfunctional cognitions through Socratic questioning.
  - Therapists are permitted to utilize techniques from other orientations
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### *Solving Practical Problems and Psychological Symptoms*

In addition to treating undiagnosed psychiatric disorders or isolated symptoms of anxiety or depression, cognitive behavioral therapy can serve a number of other important functions for clients with chronic conditions (White 2001). Cognitive behavioral therapy can address a number of practical issues faced by a client and his or her health care professionals. These include, but are not limited to, the ten uses presented in Table 2.

TABLE 2. Ten reasons to use cognitive behavioral therapy for clients with chronic conditions.

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- Facilitate compliance with medical treatments
  - Provide emotional support and stability to a newly diagnosed client in crisis
  - Prevent or reduce behaviors that have negative consequences for a client's health (eating disorders, overactivity or underactivity, smoking, substance abuse)
  - Increase clients' access to social, economic, and physical resources
  - Empower clients to take responsibility for their own health care and decrease reliance on medical providers and family members for care
  - Facilitate a sense of perceived control over symptoms and teach clients to become their own therapist
  - Provide clients with health-related education and a framework within which to make decisions about treatment options
  - Improve health status and immune functioning through stress management
  - Address nonspecific symptoms of chronic conditions that are often difficult to manage and treat with medication or other medical treatments alone
  - Reduce a client's overall health expenditures due to anxiety-related somatic symptoms or misinterpretation of minor symptoms as serious problems, overutilization of medication, and excessive doctor-shopping
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### *Addressing Unique Challenges of Psychotherapy with Clients with Chronic Conditions and Impairments*

The practice of psychotherapy with individuals with chronic conditions presents unique challenges that are not always encountered in general psychotherapy practice with individuals without chronic conditions (Guthrie, 1996). The inevitable stressors and losses associated with chronic illness are invariably linked to a heightened intensity and wider range of psychological symptoms and emotional reactions to everyday stressors. Clients with chronic illness may also be more likely to present in states of crisis and can present existential issues that involve suicide or other issues associated with death and dying.

In many cases, clinicians are presented with ambiguity regarding issues involving differential diagnosis and the origin of symptoms. For example, anxiety and depressive disorders are sometimes difficult to identify in individuals with chronic conditions given the significant amount of overlap between physical symptoms that may be common to both disorders. Symptoms such as low self-worth, depressed or anxious mood, hopelessness, suicidal ideation, and anhedonia can serve as key discriminators between psychological and physical conditions. Identifying cognitive errors, such as catastrophic thinking about a nonterminal chronic condition that does not warrant this kind of thinking, can also serve as an important discriminator.

Another challenge involves difficulties differentiating between somatic presentations of psychological symptoms and the actual physical disorder itself. Still other challenges may involve alterations in the way clients are referred for therapy, changes to the length of sessions, and new settings in which psychotherapy takes place. There may also need to be adjustments to the pace of psychotherapy based upon client stress levels and reactions to the change process.

One of the most significant of these challenges involves achieving an accurate understanding of the client's physical, emotional, and cognitive experience of chronic illness and the ongoing synergies between them. Cognitive assessments and other more informal approaches to ongoing evaluation, such as Socratic questioning, serve an integral aspect of cognitive behavioral therapy. The heavy reliance on ongoing assessment in cognitive behavioral approaches is ideal for clients with chronic conditions because assessments offer a direct and highly structured means of ongoing monitoring of cognitions, affective experience, physical symptoms, and behaviors. This not only facilitates clients' awareness of the cognitive model, or conceptualization of their problem, but it also leads to self-monitoring and self-management of symptoms.

### *Empirical Support*

Other reasons for using cognitive behavioral therapy to treat individuals with chronic conditions include the fact that it has the most empirical support, and is arguably the psychotherapy of choice, for many chronic illnesses, including HIV/AIDS, cancer, rheumatoid arthritis and other chronic pain disorders, insomnia,

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gastrointestinal disorders, and chronic fatigue syndrome (White, 2001). A growing number of research studies point to positive outcomes of cognitive behavioral approaches that involve reductions in symptom severity and improvements in self-efficacy, physical functioning, and quality of life (e.g., Antoni et al., 2001; Haddock et al., 2003; Lorig, Manzonsen, and Holman, 1993)

### Why Include Related Knowledge along with Cognitive Behavioral Therapy?

Although the primary focus of this text is on the use of cognitive behavioral theory and approaches, it will include the use of other “related” knowledge and approaches. An increasing number of studies have shown that cognitive behavioral therapy is in an ideal position to be the therapy of choice to treat individuals with a wide range of chronic conditions. However, like all approaches, cognitive behavioral approaches in general do have limitations (Beck, 1996). These limitations may be more pronounced when considering chronic conditions that often involve complex symptom pictures that include both physical and psychological components.

One of the main strengths of the cognitive behavioral approach is that it allows for the incorporation of techniques from other orientations. Related knowledge and therapeutic strategies offered by other orientations can serve to strengthen, supplement, and add to existing cognitive behavioral techniques in the treatment of individuals with chronic conditions. In this book, three areas of related knowledge will be highlighted as offering certain perspectives and therapeutic strategies not emphasized in traditional approaches to cognitive behavioral therapy. These include the emphasis on empathy offered by self psychology (Kohut, 1971, 1977, 1984), the emphasis on hope offered by the positive psychology movement (Seligman and Csikszentmihalyi, 2000), and the emphasis on volition offered by the model of human occupation (Kielhofner, 2002).

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