Cognitive Behavioral Therapy (CBT): Refining & Consistently Applying Essential Skills

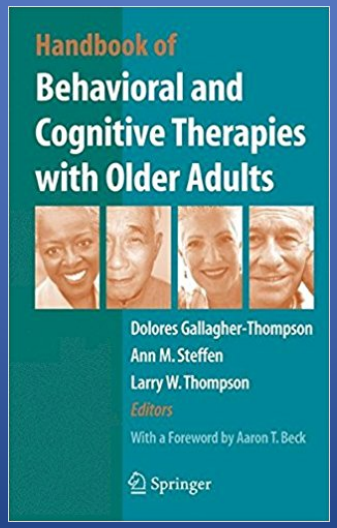
Ann M. Steffen, Ph.D., ABPP

Missouri DMH Spring Training Institute 2019

Conflict of Interest

Presenter's relationship w/ webinar materials -

I do benefit from royalties from this book:



Objectives

After this 3 hour workshop, you should be able to:

1. Identify the essential defining features of the CBTs and describe the rationale for each
2. Identify 1-2 core components of the CBTs to competently apply in next month with current patients/clients
3. Create a plan for continued professional development in the CBTs

Cognitive Behavioral Therapy (CBT): Refining & Consistently Applying Essential Skills

Part I

A theoretical orientation …

(Pugh, Karpiak, Norcross & Wedding, 2016)

- Consistent perspective on human behavior
- Explanation of psychopathology
- Mechanisms of therapeutic change
- Thus…much more than collection of therapy brand names, set of change principles or clinical techniques!
- Helps us prioritize and direct both assessment and intervention approaches

Misconceptions about CBTs:

- CBT is a type of therapy….all CBTs look pretty much alike, and focus on techniques rather than conceptualization.
- Behavioral and cognitive therapies are new….in fact, quite a long tradition…continuing shifts from 1920s to 1950s to 1980s to now.
- All CBT clients are treated alike, very rote and packaged form of intervention.

Instead…

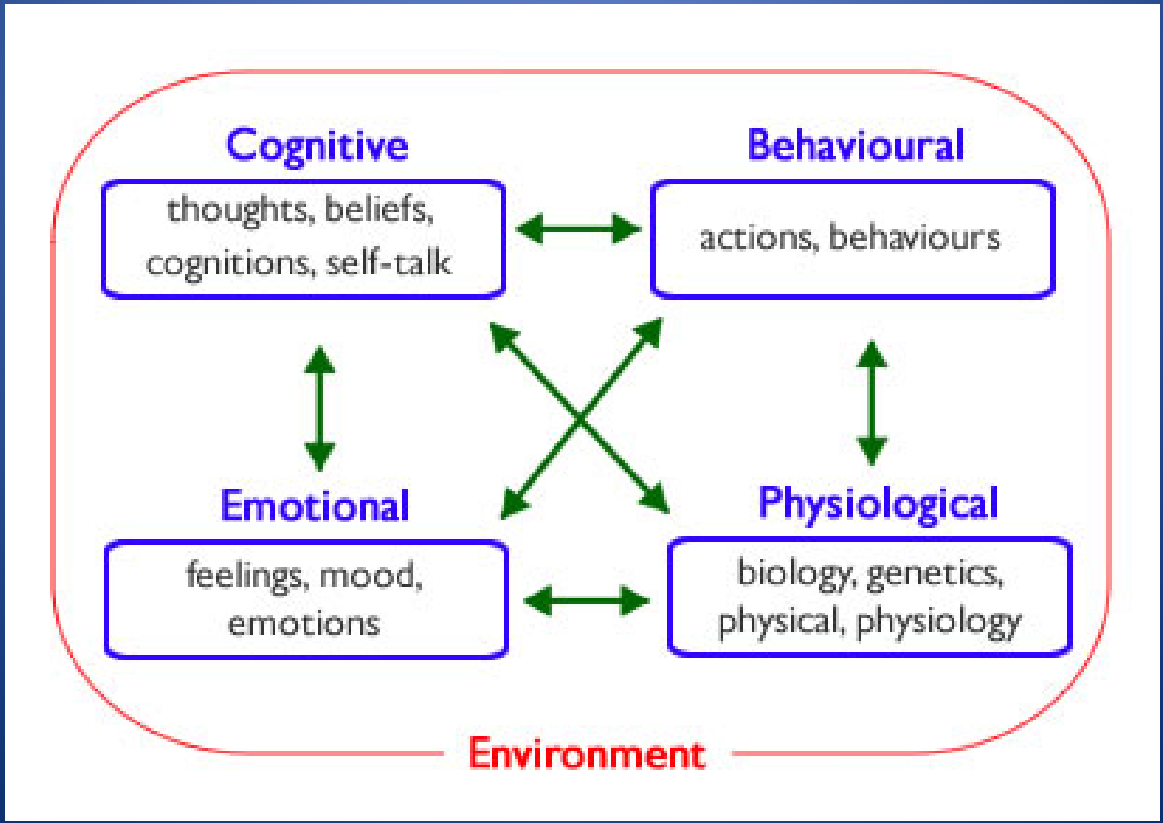
There are multiple forms of CBTs (we will focus on an integrated cognitive-behavioral approach and call it “CBT”)

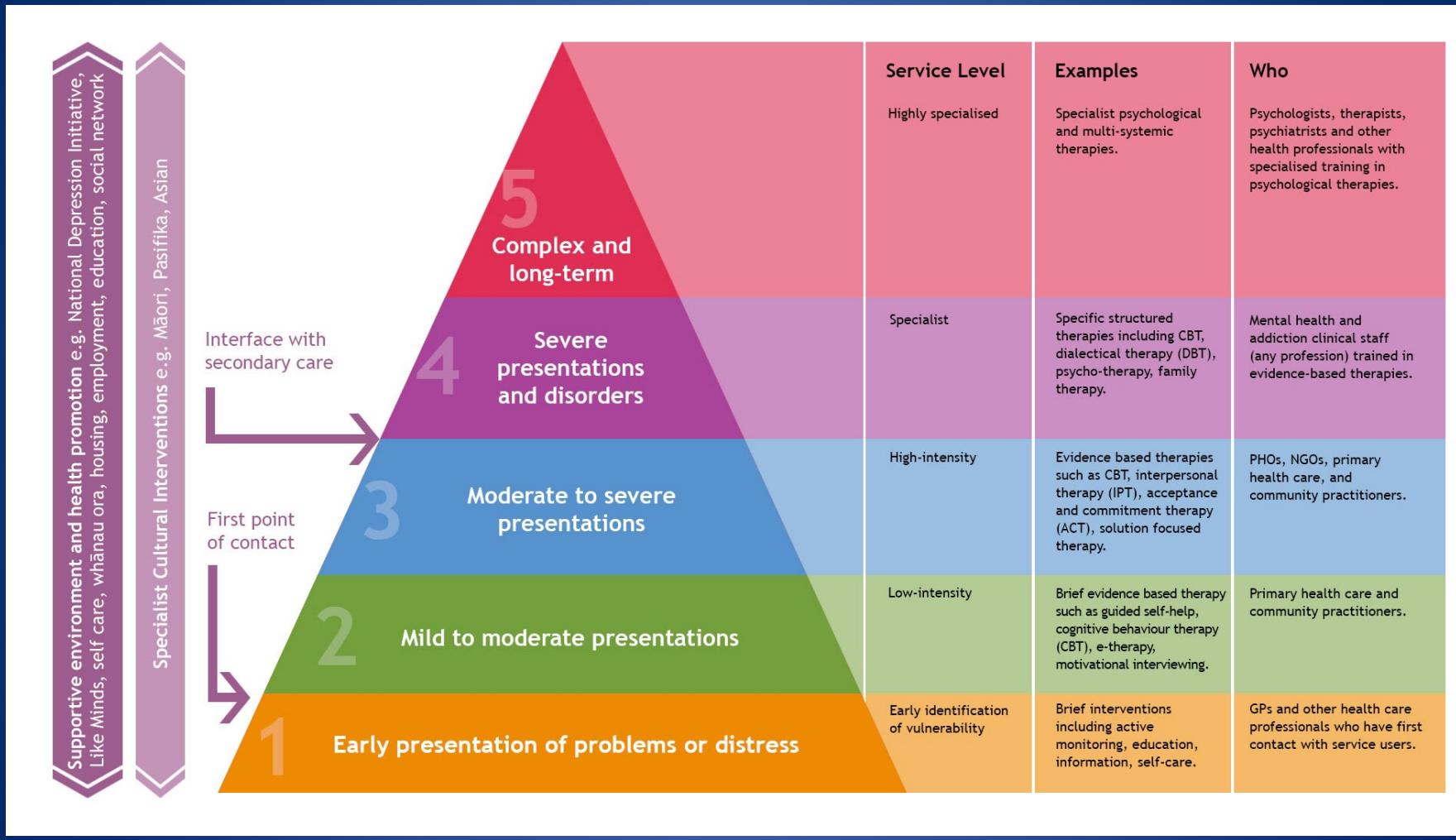
Conceptualizations from this CBT framework focus on:

- How did problem develop, continue and how is it currently maintained?
- What should we assess and how frequently?
- What focus should treatment take?
- After treatment, how do earlier changes stick over time?

“Cognitive therapies” = “Cognitive-behavioral therapies”

A biopsychosocial model with a core focus on the interconnections among cognitions, behaviors and emotional responses (within the context of specific environments)




Supportive environment and health promotion e.g. National Depression Initiative, Like Minds, self care, whānau ora, housing, employment, education, social network
Specialist Cultural Interventions e.g. Māori, Pasifika, Asian
Interface with secondary care
First point of contact
5
Complex and long-term
4
Severe presentations and disorders
3
Moderate to severe presentations
2
Mild to moderate presentations
1
Early presentation of problems or distress
Service Level
Examples
Who
Highly specialised
Specialist psychological and multi-systemic therapies.
Psychologists, therapists, psychiatrists and other health professionals with specialised training in psychological therapies.
Specialist
Specific structured therapies including CBT, dialectical therapy (DBT), psycho-therapy, family therapy.
Mental health and addiction clinical staff (any profession) trained in evidence-based therapies.
High-intensity
Evidence based therapies such as CBT, interpersonal therapy (IPT), acceptance and commitment therapy (ACT), solution focused therapy.
PHOs, NGOs, primary health care, and community practitioners.
Low-intensity
Brief evidence based therapy such as guided self-help, cognitive behaviour therapy (CBT), e-therapy, motivational interviewing.
Primary health care and community practitioners.
Early identification of vulnerability
Brief interventions including active monitoring, education, information, self-care.
GPs and other health care professionals who have first contact with service users.

CBT: Common Core Assumptions

(O'Leary & Wilson, 1987)

- Most abnormal behavior is acquired and maintained according to the same principles as normal behavior.
- Most abnormal behavior can be modified through the application of social learning principles.
- Assessment is continuous and focuses on the current determinants of behavior.

CBT: Common Core Assumptions

(O'Leary & Wilson, 1987)

- People are best described by what they think, feel and do in specific life situations.
- Treatment methods are precisely specified, replicable, and objectively evaluated.
- Treatment outcome is evaluated in terms of the initial induction of behavior change, its generalization to the real life setting, and its maintenance over time.

CBT: Common Core Assumptions

(O'Leary & Wilson, 1987)

- Treatment strategies are individually tailored to different problems in different individuals.
- CBTs are broadly applicable to a full range of clinical disorders and educational problems.
- CBTs reflect a humanistic approach in which treatment goals and methods are mutually contracted between the client and therapist.

Principles of Change in CBTs
(O'Donohue & Fisher, 2012)

- Clinical Functional Analysis
- Skills Training
- Exposure Therapy: Promoting emotional processing of pathological anxiety
- Relaxation
- Cognitive Restructuring
- Problem Solving

Principles of Change in CBTs
(O'Donohue & Fisher, 2012)

- Self-Regulation
- Behavioral Activation
- Social Skills
- Emotion Regulation and CBT
- Communication
- Principles of Positive Psychology
- Acceptance and Cognitive Behavior Therapy

Evidence in support of CBTs for general population (Hofmann et al., 2012)

- Identified 269 meta-analytic studies and reviewed 109, showing CBTs are effective across range of populations and problem areas

- 80% since 2004, with treatment literature constantly growing

CBTs : Supporting Evidence

Across range of:

- Modes of delivery (guided bibliotherapy, telephone, groups, family, clinical video teleconferencing, traditional individual)

- Treatment settings (home, community, medical, long-term care)

- Interventionists (counselors, nurses, psychologists, social workers, occupational therapists, supervised paraprofessionals)

Common elements of CBTs

- Collaborative therapeutic relationship
- Focus on small number of clearly specified goals
- Emphasis on changes within daily life
- Psycho educational
- Length of therapy contracted and linked to goals
- Skill training (cognitive, behavioral, interpersonal)

Common elements of CBTs

- Problem identification and goal setting
- Ongoing assessment to guide interventions and evaluate progress
- Between session work (call it “home practice”, not “homework”)
- Session structure (agenda, home practice review, specific skill building using 1-3 areas of client’s life, periodic summaries, developing home practice)

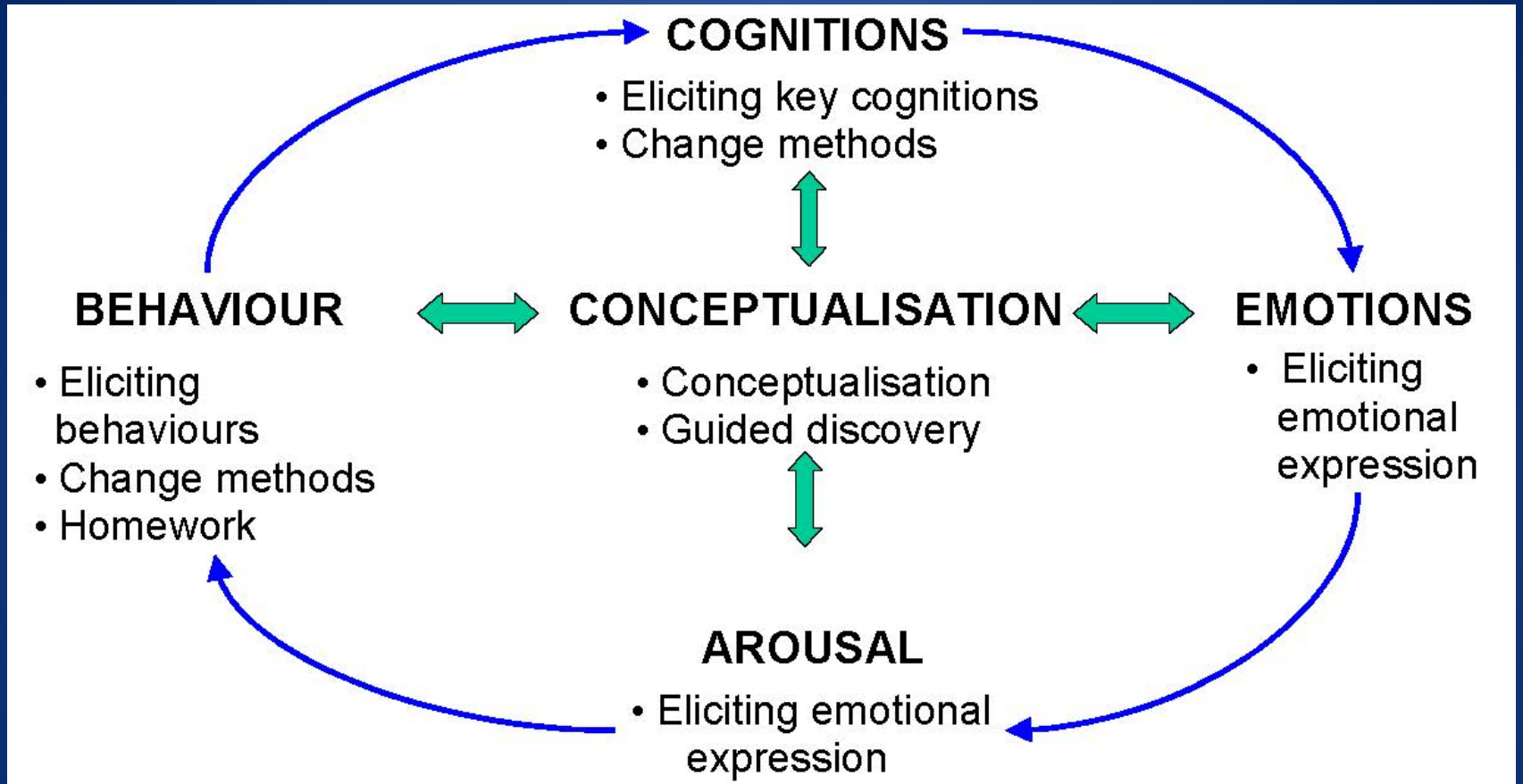
Do you really know CBT?
Practitioner's Checklist (Beck Institute, 2018)

- Cognitive conceptualizations
- Strong therapeutic relationships
- Setting full agendas and structuring sessions
- Using guided discovery
- Modifying core beliefs
- Creating action plans that clients complete
- Responding to negative feedback
- Eliminating key factors that maintain disorder

These common elements of CBTs stay consistent for:

- Psychoeducational groups = “classes” (e.g., chronic pain, sleep, stress management, caregiving concerns)
- Brief interventions in healthcare settings
- Individual/family CBT in behavioral health “specialty care”

Blackburn et al (2001)



Items facilitating movement around circle

- Agenda Setting
- Feedback
- Collaboration
- Pacing & Efficient use of time
- Interpersonal Effectiveness

Practice Tip #1 - Feedback Routine Outcome Monitoring

- Behavioral health clinicians overestimate improvements (report 85% of clients improving)
- Physicians don't expect to manage illnesses without lab data
- Clinical research shows that we can identify between 85-100% who deteriorate, well before they drop out of therapy

Feedback
Routine Outcome Monitoring

- Regularly measuring and tracking client progress, session by session, throughout treatment
- Same standardized self-report scale for all clients
- Provides feedback to clinicians in time to strategically intervene
- Strongly linked to positive therapy outcomes in routine care
- Example: OQ Analyst Feedback System

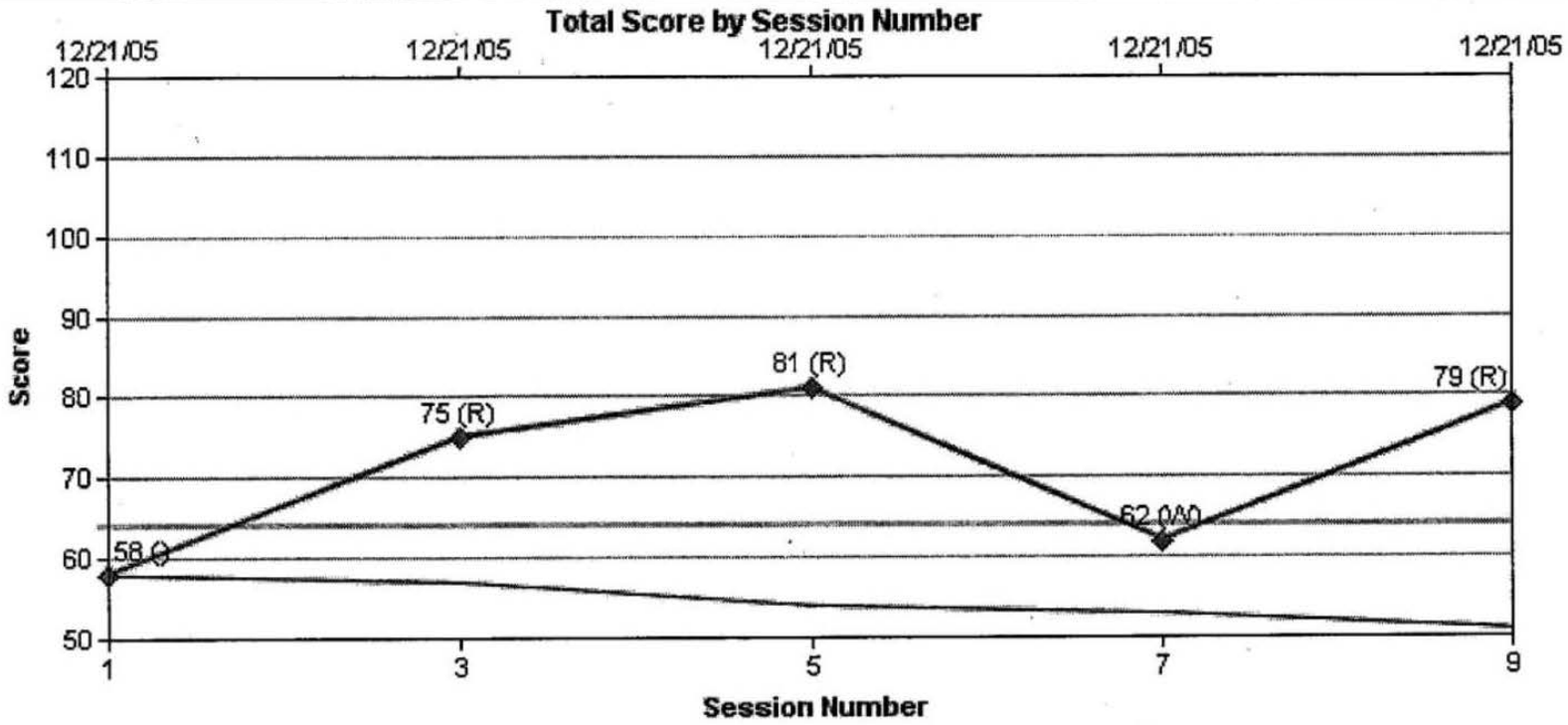
Name:	12, case	**ID:**	12
Session Date:	12/21/2005	**Session:**	9
Clinician:		**Clinic:**	Aigle
Diagnosis:	Unknown Diagnosis		
Algorithm:	Empirical		

Alert Status:	**Red**
Most Recent Score:	79
Initial Score:	58
Change From Initial:	Reliably Worse
Current Distress Level:	Moderate

Most Recent Critical Item Status:

8.	**Suicide** - I have thoughts of ending my life.	**Never**
11.	**Substance Abuse** - After heavy drinking, I need a drink the next morning to get going.	**Never**
26.	**Substance Abuse** - I feel annoyed by people who criticize my drinking.	**Never**
32.	**Substance Abuse** - I have trouble at work/school because of drinking or drug use.	**Never**
44.	**Work Violence** - I feel angry enough at work/school to do something I might regret.	**Rarely**

Subscales	Current	Outpat. Norm	Comm. Norm
Symptom Distress:	45	49	25
Interpersonal Relations:	18	20	10
Social Role:	16	14	10
Total:	**79**	**83**	**45**



Graph Label Legend:

(R) = **Red**: High chance of negative outcome (Y) = **Yellow**: Some chance of negative outcome

(G) = **Green**: Making expected progress (W) = **White**: Functioning in normal range

Feedback Message:

The patient is deviating from the expected response to treatment. They are not on track to realize substantial benefit from treatment. Chances are they may drop out of treatment prematurely or have a negative treatment outcome. Steps should be taken to carefully review this case and identify reasons for poor progress. It is recommended that you be alert to the possible need to improve the therapeutic alliance, reconsider the client's readiness for change and the need to renegotiate the therapeutic contract, intervene to strengthen social supports, or possibly alter your treatment plan by intensifying treatment, shifting intervention strategies, or decide upon a new course of action, such as referral for medication. Continuous monitoring of future progress is highly recommended.

Practice Tip #2
Identifying Target Complaints

Name/ID: ________________ **Date** __________________

Target Complaints Interview

"As you think about your current life situation, what are the things that are most bothersome or stressful for you to deal with?. I would like to help you really "pin point" three aspects of your life that trouble you the most, so that we can focus on these in our work together." (Listen to response. Probe for examples and details. List up to 3 problems. Don't worry about order under end, when you ask client to rank order by importance to them.)

_____ **Problem Description:** ____

As you think about this specific situation/aspect of your life, how much do you feel the following:"

	Not at all	A little	Moderately	Very Much	Extremely
Upset	1	2	3	4	5
Sad	1	2	3	4	5
Worried	1	2	3	4	5
Frustrated	1	2	3	4	5
Irritated	1	2	3	4	5

_____ **Problem Description:** ____

As you think about this specific situation/aspect of your life, how much do you feel the following:"

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Sad	1	2	3	4	5
Worried	1	2	3	4	5
Frustrated	1	2	3	4	5
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_____ **Problem Description:** ____

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Sad	1	2	3	4	5
Worried	1	2	3	4	5
Frustrated	1	2	3	4	5
Irritated	1	2	3	4	5

Practice Tip #3
Turn Target Complaints into Specific Therapy Goals

Specifying Treatment Goals

Positively worded:

- Important to client
- Specific
- Measureable
- Realistic
- Time-limited

If treatment is a success in regards to this goal, I will probably (behaviors/events):

If treatment is partially successful, I will probably:

If this goal is not met at all, I will probably:

Setting Specific, Concrete and Manageable Treatment Goals

Questions to ask clients about primary goals for treatment*

1. Do these goals involve changing things about you?
2. Do these goals involve changing things that are in your control?
3. Are your goals realistic?

Questions to ask clients to make it more concrete

(Visible to a fly on the wall, or a hidden camera….)

1. What would it look like once you have achieved your treatment goal?
2. What things would you be doing, or not doing?
3. What behaviors would you be engaging in?
4. What behaviors would you not be engaging in?

Questions to ask clients to help list necessary steps*

(These steps can take a few days, a week, or up to a month)

1. What small steps would show that you are inching towards the goal?
2. What do you need to do first before the final goal is possible?
3. What would be the first sign that you are making progress?
4. If this were a friend's goal, what would you advise her or him to help them get started?
5. Are there one or two smaller changes that would make you feel better and let you know you are on the right track?

*Greenberger & Padesky, 2015

Practice Tip #4
Home Practice

Principle:

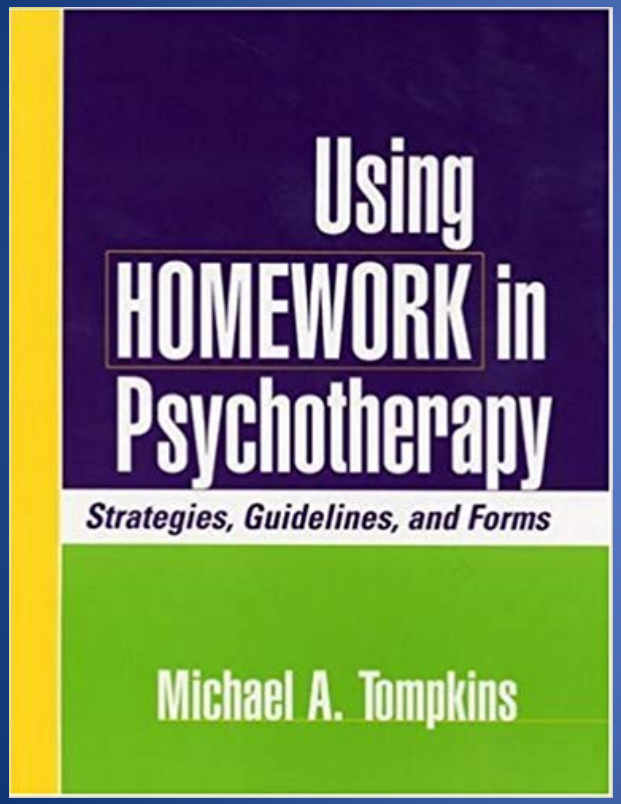
Within CBT, the most important experiences linked to change/improvement happen OUTSIDE of therapy sessions.

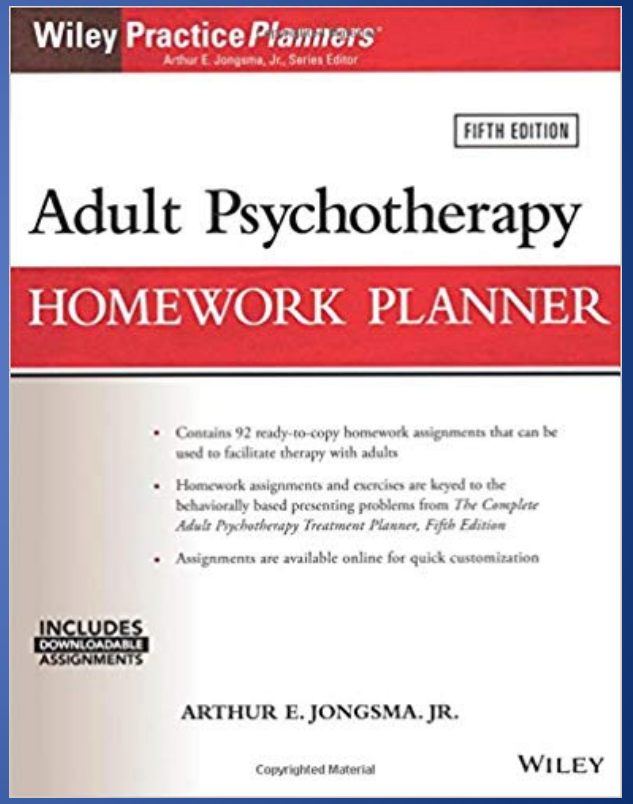
Therapy sessions are in the service of facilitating those learning opportunities in daily life.

Developing and Assigning "Home Practice":

- **<u>Always</u>**....
  - Directly link to a concrete therapy goal ("We are experimenting with best ways to help you with your goal to _____. This activity will help us by ....")
  - Do one small piece together (based on day of session, previous day, etc) with client writing it in the appropriate space, as an example
  - Ask, "How likely do you think it is that you will fill this out and bring with you to our next meeting?"(if < 80%, ask, "What can we change to meet your needs?")
  - Allow time in next session to review and discuss

Insert picture of Homework book





Looking for Everyday Exceptions: Home Practice

One of the problems that I'm looking for help with is:

_____

In the space for each day, I will take 5 minutes and write down 1-2 times / situations each day when I was less aware of or less bothered by this problem. I will bring this form to our next meeting on: _____ at _____(am/pm).

Day/ Date:	Some details about when I was less bothered by this problem: (Time of day? Location? With others or alone? What was happening?)

Practice Tip #5
Multi-modal learning and storage

Principle:

Don’t overly rely on verbal discussions without means of retaining over time.

Written summaries promote learning
(for everyone, including clients)

- Have either workbook or folder with handouts ready at the end of very first meeting, with something to get started.
- Routinely use session summary sheets at the end of each session. Encourage clients to review a few times between sessions, including night before next session.
- Routinely use session preparation sheets before each session.
- If using a workbook for clients, embed the cost into fees for first 3 sessions.

Session Summary Form

Date of Session: _____

Today, we focused on:

I'd like to especially remember:

Before my next appointment, I am going to specifically work on:

My next appointment is:

Preparing for Session Form

Date of Session: _____

Either at home or in the waiting room before my session, I should spend no more than 5-10 minutes to jot down a few words or phrases in each section below….

What did we talk about/work on in last session?

What was I trying to practice at home? Did I have a specific between-sessions assignment? Did I have any difficulties with this? Learn anything new?

What do I want my therapist to know about the past week? Have there been any major changes in my condition or life?

What would I like to be sure to talk about in today's session?

Cognitive Behavioral Therapy (CBT): Refining & Consistently Applying Essential Skills

Part II

CBT:
Relationship between assessment, goal setting and intervention phases

- Assessment and intervention are integrated and less distinctly separate than with other approaches
- Clinician begins collaborative case conceptualization within first meeting, by asking for client's understanding of problem origins and maintenance
- Emphasis on importance of gathering data throughout each session. Assessment is never done, and intervention begins early.

Setting up your space

Addressing Diversity in CBT

(Hays, 2009)

1. *Assess the person's and family's needs with an emphasis on culturally respectful behavior.*

2. *Identify culturally related strengths and supports.*

3. *Clarify what part of the problem is primarily environmental (i.e., external to the client) and what part is cognitive (internal), with attention to cultural influences.*

Addressing Diversity in CBT

(Hays, 2009)

4. For environmentally based problems, focus on helping the client to make changes that minimize stressors, increase personal strengths and supports, and build skills for interacting more effectively with the social and physical environment.

5. Validate clients' self-reported experiences of oppression.

6. *Emphasize collaboration over confrontation, with attention to client–therapist differences.*

Addressing Diversity in CBT

(Hays, 2009)

7. With cognitive restructuring, question the helpfulness (rather than the validity) of the thought or belief.

8. Do not challenge core cultural beliefs.

9. Use the client's list of culturally related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones.

10. Develop weekly home practice assignments with an emphasis on cultural congruence and client direction.

Mood Monitoring

- Rationale: By keeping track of your daily mood, you put yourself in a position to:
  - Identify specific interactions, activities, and situations where you feel especially good or bad.
  - Evaluate your progress toward overcoming your depression or anxiety.

Mood Monitoring: Using In Session the First Time

- Create a daily mood rating scale together with the patient (form: Daily Mood Rating Form)
- Ask: “Have you ever seen a form like this before, a 1-10 point scale?”
- Explain rationale for using mood monitoring. “This is going to help both of us understand more what your days are like, and what contributes to your shifts in mood.”

Mood Monitoring: Using In Session the First Time

- Anchor numbers to adjectives and experiences.
  - 10: best time you ever had -- when was this? What adjectives can you think of to describe this?
  - 1, 5, 7, 3

Mood Monitoring: Using In Session the First Time

- Rate the previous day, so the patient can get the experience of completing the form.
  - "Why I think I felt this way" is anything they felt might be responsible for mood that day. For someone more concrete, change to "what did I do today."

Mood Monitoring: Using In Session the First Time

- Discuss when the patient will complete the form, and how the patient will remember.
  - Agree on a time of day and/or activity that is done daily to which you can link mood monitoring.
- Everyone has off days, and even happy people don't feel like a "10" all of the time. Don't expect "peak" days.

Mood Monitoring: The Following Session

- Review the form together.
  - Notice the range, the high's, the low's, and what was happening on those days.
  - Make hypotheses regarding the connection between mood and activity.

Behavioral Activation

Individuals experiencing chronically low levels of mood need to break out of the vicious cycle by reinstituting events in their lives that result in feelings of pleasure and mastery.

To do this, the individuals have to learn that daily events do affect their mood and that they have at least some degree of control over the events they experience each day.

Pleasant Events

"4 pleasant events a day,
keep the blues away."

If they are Consciously Chosen
and Deliberately Done

Pleasant Events

- Activity scheduling/pleasant events
  - Anything that can add pleasure to someone's day
  - Activities to feel useful, competent, capable, adequate
  - Social interactions, if pleasant and meaningful
  - Consistent with health goals, e.g., exercise/physical activity
- Activity and mood logs, schedule daily activities

Pleasant Events: Using In Session the First Time

- Review rationale for use of instrument.
- Go through first 1-2 items together, ensuring they understand the task.
- Assign as home practice, if they understand how to complete the measure.

Pleasant Events: The Following Sessions

- Create list of PE's to track (Form: Tracking your Pleasant Events) (Options range from: assigning this as home practice, to completing together in session).

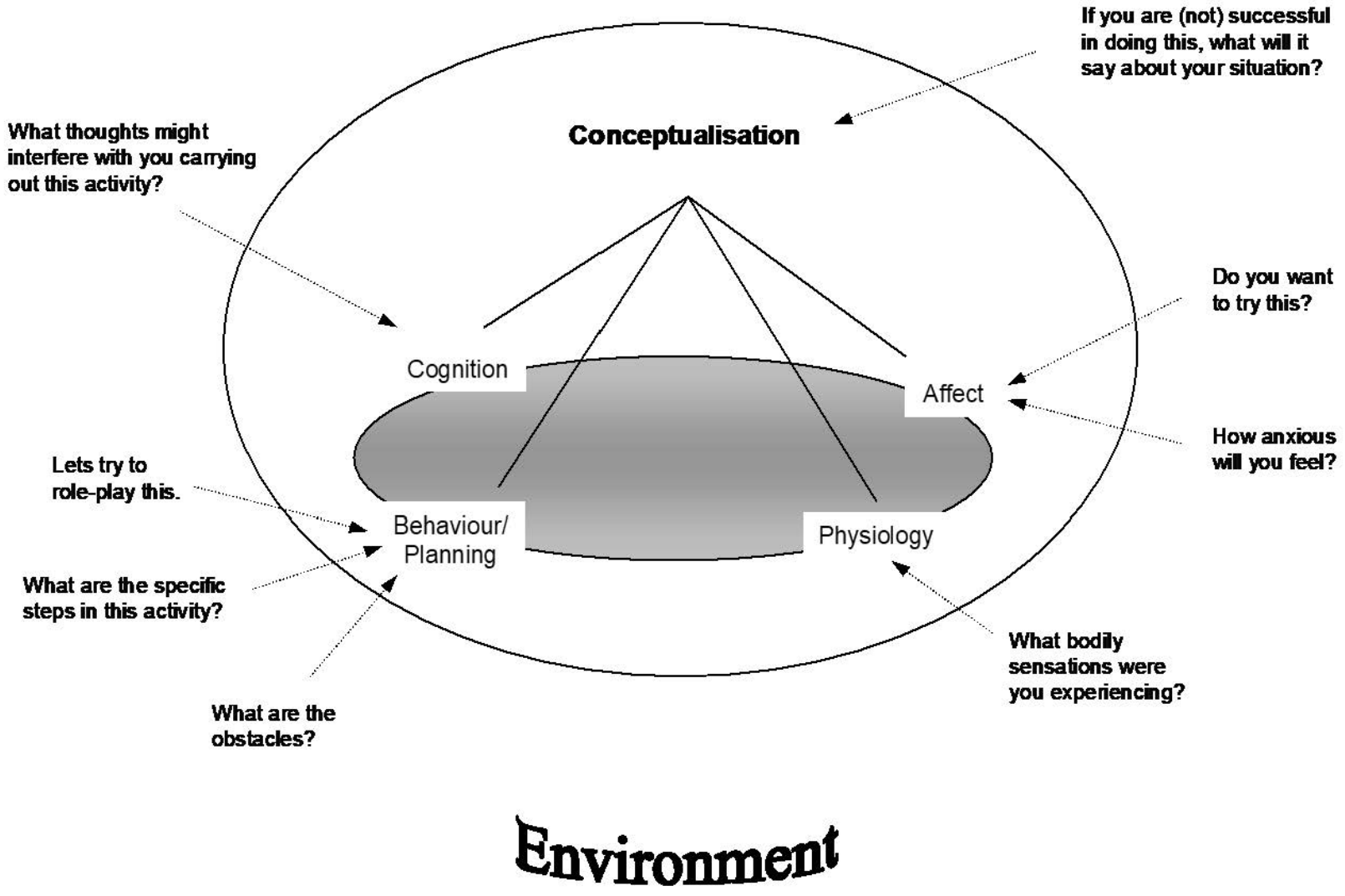
- Total PE's (from Tracking Your Pleasant Events Form) and Mood scores (from Daily Mood Rating Form), plot totals on graph (Form: Relationship Between Activities and Mood) and examine relationship.

Troubleshoot obstacles to activities

- Lack of time.
- Plan is too complicated, more trouble than it’s worth.
- Participant refuses to participate.
- Negative behaviors interfere with pleasant activities.

Blackburn et al (2001)

Figure 11.1: Examples of questions used when planning a behavioural intervention



Working with Upsetting Thoughts

In both the origins and current articulation of cognitive interventions:

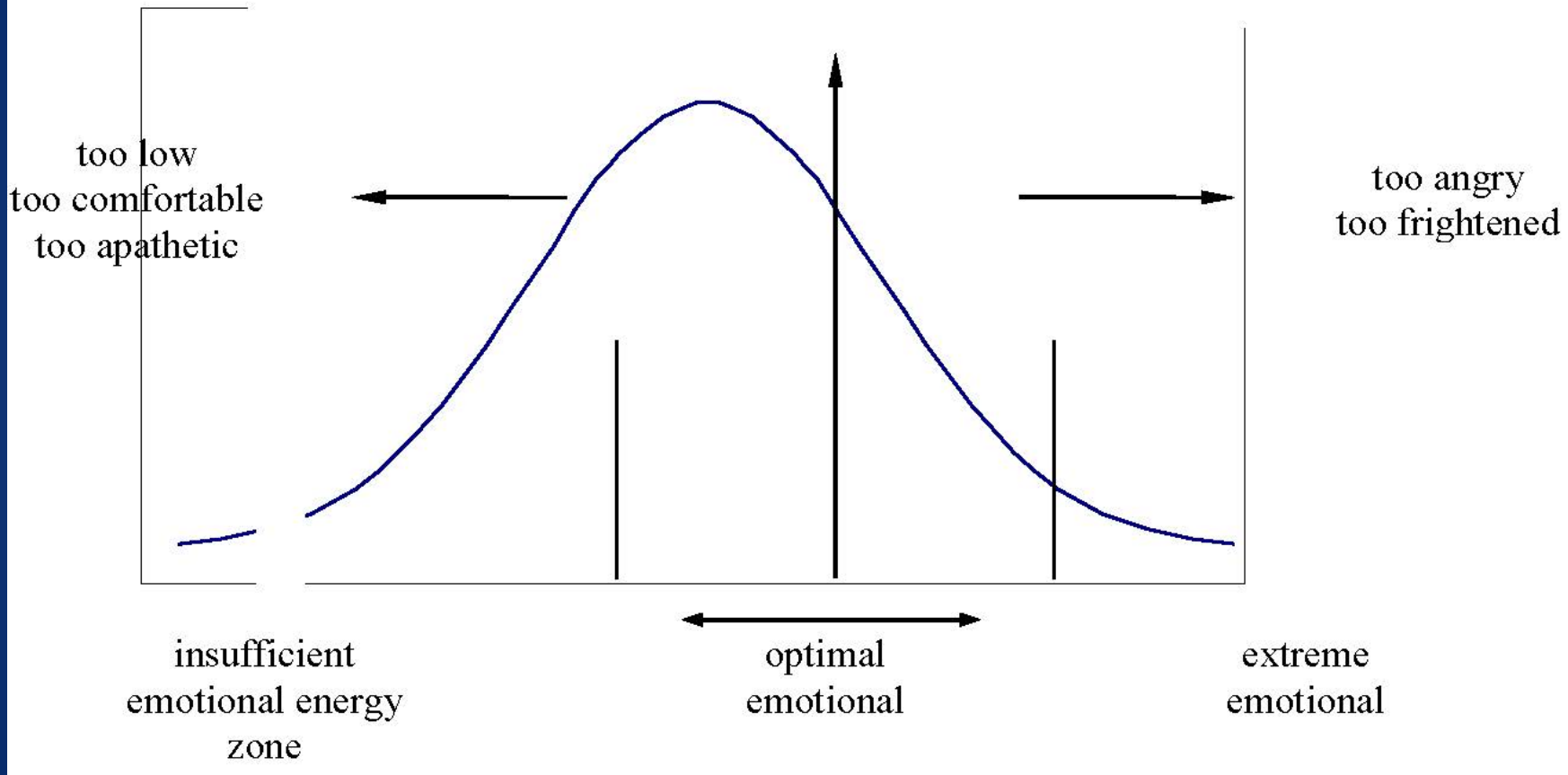
- Clinician does not directly challenging client's thoughts. Instead, facilitates client learning to challenge their own thinking patterns.

(only exception is with acute suidical ideation/imminent risk)

- Collaborative work in selecting a focus on only those thoughts that are both upsetting and not amenable to problem solving/behavioral skills training.

Blackburn et al (2001)

Figure 6.1: Curve of energy levels for optimal learning



Working with Upsetting Thoughts

In both the origins and current articulation of cognitive restructuring:

- Examining the evidence is only 1 of a variety of questions that clients can ask themselves:
  - Is there an alternative explanation?
  - What's the worst that could happen and how could I cope? What's the best that could happen? What's the most realistic outcome?
  - What's the effect of my believing this thought? What could be the effect of changing my thinking?
  - If (friend's name) was in this situation and had this thought, what would I tell him/her?
  - What should I do about it?

Cognitive interventions

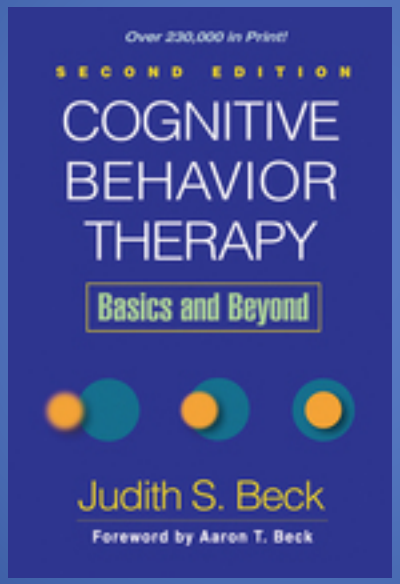
- Usually start with behavioral activation first
- Be sure to evaluate if problem solving is more appropriate
- Work in session using specific recent events/situations
- Break skills needed in cognitive restructuring into steps
- Use self-compassion exercises to increase client's ability to treat difficulties gently

Cognitive interventions

- Use worksheets; cross out whatever you haven't yet worked together on
- Emphasize other restructuring questions over examining the evidence
- Plan on lots of repetition, across multiple occasions/situations

Cognitive Interventions

- If minimal training and supervision in CBT, start with:



Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond*. Guilford Press.

Agenda Setting

- What would you like to get from today's session?
- As usual at the beginning of the session, we need to set a plan.
- What benefits do you think we get by setting the agenda?
- Perhaps we need to put some time for X.
- What is the most important thing to cover today? ... Are there any other things to include?
- Is there anything that has been troubling you this week, which might help to illustrate your problems?
- You have mentioned X, Y and Z. Which of these would you like to talk about first?
- If we did discuss this item, how would it help take the therapy forward?
- What would be most helpful to discuss today, keeping in mind the stage we're at in therapy?
- By discussing X, how will this help us move forward?

Feedback

- Could you tell me the three most important issues we've discussed today?
- Just to summarise, at the beginning of the session we spoke about X and the effect it had on your feelings. Then we discussed Y, etc. etc.
- I think I have understood what you just said, let me see if I can repeat back the main points.
- Could you tell me whether I’ve got that right?
- Is there anything that I’ve said, that didn’t make sense?
- What was the most/least helpful thing that we discussed today?

Collaboration

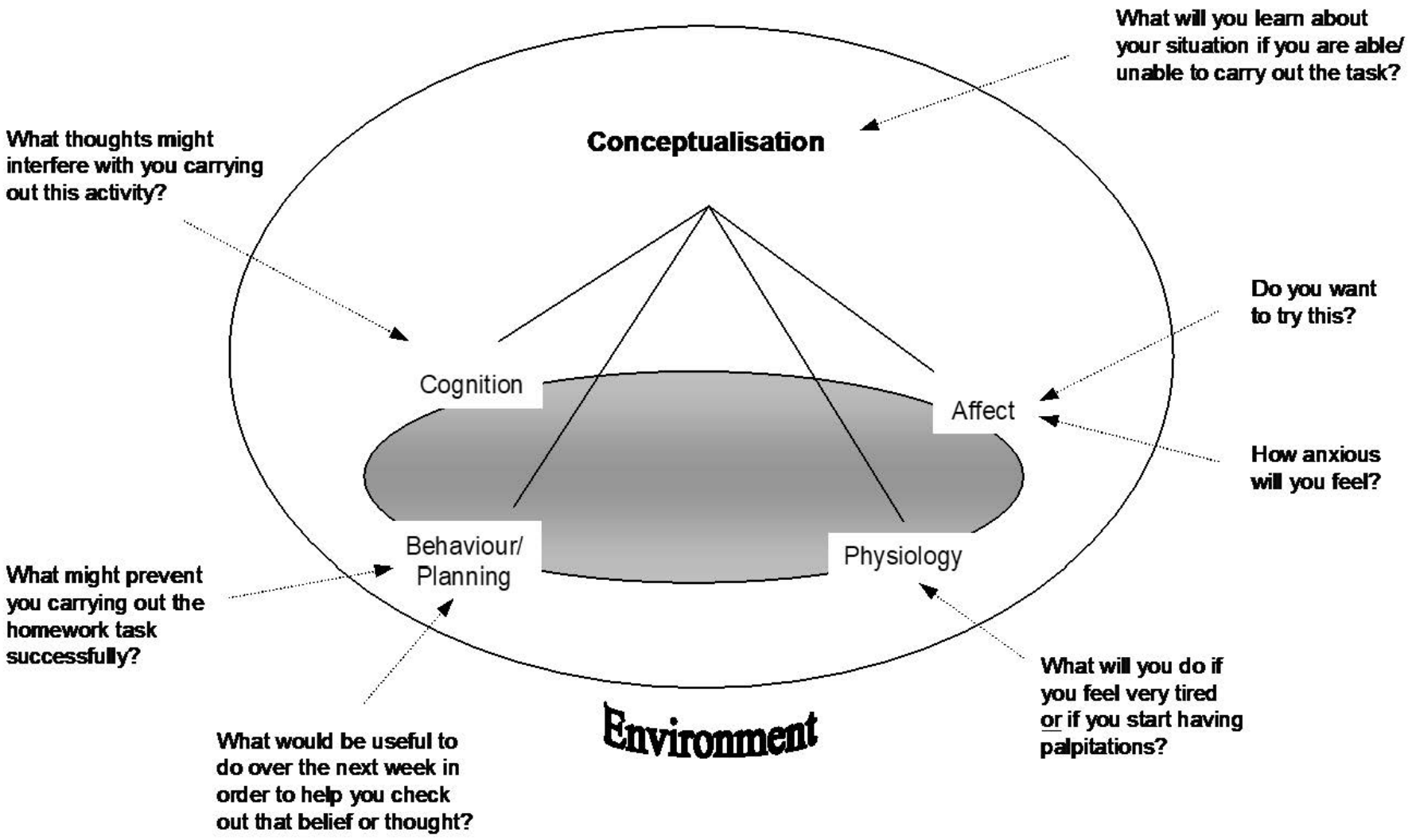
- How might we test that out?
- Perhaps we could work out together an alternative way of looking at this issue.
- Before setting this behavioural task, let's both examine the potential obstacles which might prevent us learning anything from it.
- That's a difficult one, so let's put our heads together and try and think it through.
- Could you help me make sense of this?
- I’m sure that together we can work this one out.
- Let’s look at this together.
- You’re the expert with respect to your problem, so could you help me understand?
- You’ve got your homework, so would you like me to do anything for next week?

Pacing and Efficient Use of Time

- How much time should we spend on that item?
- Do you mind stopping a second, you've given me lots of information already. Just to make sure I have understood completely, let's look at the major points you've made.
- We may have strayed off the topic a little, shall we get back and focus on the chief issues you raised.
- Now we have 20 minutes left before the end of the session. Is there anything you think we must cover before the end - keeping in mind that we will also need to set the homework assignment?
- Do you think we should move off this topic now?

Blackburn et al (2001)

Figure 12.1: Examples of questions used when setting homework assignments



Home Practice: Did I…

1. …adequately explain the rationale underpinning the assignment?
2. …check that the patient was confident about conducting the task correctly?
3. ….check that the patient saw the relevance of the assignment?
4. …adequately plan the assignment within the session?
5. …discuss obstacles to conducting the plan?
6. …link to learning goals?
7. …ask likelihood of completing? Then modify if below 80%?
8. …develop homework consistent with the themes from the session?
9. …explain task sufficiently?
10. …ask patient to describe what can be usefully learned from engaging in this task?

My next steps….

Within the next month, I plan to:

1.

2.

3.

I will share this plan with _____ and discuss how they can hold me accountable.

(Presenter's email: ann_steffen@umsl.edu).