Cognitive Behavioral Therapy

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Purposes of Today’s Dialogue

• Describe the use of cognitive behavioral therapy (CBT) in psychiatric mental health (PMH) settings
• Discuss the components of CBT
  – Cognitive
  – Rational emotive
• Explain the clinical application of CBT
  – Case studies
  – Treatment planning and implementation
  – Evaluation of CBT
Use of CBT in PMH Settings

Use of CBT

• For self and personal growth
  – Individuals
  – Groups
  – Families
  – Couple, partner, marital relationships
  – Workplace environments

• Mental health, wellness, illness foci
Efficacy of CBT

- Mood disorders
- Anxiety disorders
- Obsessive Compulsive Disorder
- Panic disorder

Life Just Isn’t Interesting or Fun!
Clinically: One Cannot Function!

An Ongoing Low-Grade Depression

Dysthymic Disorder

Specific Time, Season of the Year

Seasonal Affective Disorder
An Ongoing Low-Grade Depression

Extreme Energy, Out-of-Control Behavior
Low-Grade Ongoing Hyperactivity

Cyclothymic Disorder

Generalized Anxiety Disorder
Components of CBT (Cognitive, Rational Emotive)

Founders of CBT

- Epictetus: Greek philosopher, started the premise of the therapy
  - People are not disturbed by things
  - Disturbed by the view they have regarding what has happened
Depressed people have a negative view of:

• Themselves
• The world
• The future

Depressed people have negative schemas or frames of reference through which they interpret all events and experiences.
Depression and Negative Schemas

Negative schemas:
- Always present
- Unconscious
- Become activated with stressful events

Definition of CBT

- Focused form of psychotherapy
  - Mental illnesses involve dysfunctional thinking
- Structure of experiences $\rightarrow$ feelings and behaviors
Premises for CBT

• Modifying dysfunctional thinking provides improvements in symptoms and modifying dysfunctional beliefs that underlie dysfunctional thinking leads to more durable improvement

• Therapy is driven by a cognitive conceptualization and uses a variety of strategies

Premises for CBT

• Fact not assumptions
• Structured and directive
  — Maladaptive behaviors are not a result of skill deficits
  — Unwanted reactions are learned
• Therapy is driven by a cognitive conceptualization and uses a variety of strategies
• Practice and assignments
Progression of Thinking

Situation

↓

Automatic Thoughts And Images

↓

Reaction (Emotional, Behavioral and physiological)

The Cognitive Triad

• Negative view of the self (e.g., I’m unlovable, ineffective)

• Negative view of the future (e.g., nothing will work out)

• Negative view of the world (e.g., world is hostile)
The Cognitive Model

Core Beliefs

Assumptions

Compensatory/coping strategies

Situation

Automatic thoughts/images

Reaction (emotional/behavioral physiological)

CBT: Collaborative Effort
Roles

- Client
  - Define goals
  - Delineate concerns
  - Implement techniques

- Therapist
  - Assist client to define goals
  - Listen to the client
  - Teach CBT techniques
  - Reinforce and encourage

Calmness & Neutrality

- Managing difficult situations

- Use calmness and neutrality
  - Avoid 2 problems → real problem and anxiety/being upset
Albert Ellis

Rational Emotive Therapy

Premises of Rational Emotive Therapy

• Clients learn how to choose their reactions
• Self-observation and personal change
• Here and now basis
• Self-help techniques that facilitate coping
Self-Defeating Rules (Irrational Beliefs)

1. I need love and approval from those around to me.
2. I must avoid disapproval from any source.
3. To be worthwhile as a person I must achieve success at whatever I do.
4. I can not allow myself to make mistakes.
5. People should always do the right thing. When they behave obnoxiously, unfairly or selfishly, they must be blamed and punished.
6. Things must be the way I want them to be.
7. My unhappiness is caused by things that are outside my control – so there is nothing I can do to feel any better.

8. I must worry about things that could be dangerous, unpleasant or frightening – otherwise they might happen.
9. I must avoid life’s difficulties, unpleasantness, and responsibilities.
10. Everyone needs to depend on someone stronger than themselves.
11. Events in my past are the cause of my problems – and they continue to influence my feelings and behaviours now.
12. I should become upset when other people have problems, and feel unhappy when they’re sad.
13. I shouldn’t have to feel discomfort and pain.
14. Every problem should have an ideal solution.
Irrational Thinking and Emotional Disturbance

• A= Failure at work
• B= I am stupid, I’ll never be able to be good at work, I will always fail
• C= Depressive disorder

Ellis’ List of Common Irrational Ideas

• I absolutely must have sincere love and approval almost all the time from all the significant people in my life
• I must be thoroughly competent, adequate and achieving in all respects, or I must at least have real competence or talent at something important; otherwise I am worthless.
• People who harm me or who do a bad thing are uniformly bad or wicked individuals, and I should severely blame, damn, and punish them for their sins and misdeeds
Ellis’ List of Common Irrational Ideas (continued)

- When things do not go the way I would like them to go, life is awful, terrible, horrible, or catastrophic.
- Unhappiness is caused by external events over which I have almost no control. I also have little ability to control my feelings or rid myself of feelings of depression and hostility.

Clinical Application of CBT
CBT & RET

- RET:
  - Identify patient’s irrational beliefs
- CBT:
  - Teach the patient to dispute the beliefs and substitute logical and rational beliefs
  - Evaluate the effects of disputing their irrational beliefs
- Problem solving skills and assertiveness training

Case Studies
Example of Negative Thinking

• Person with negative schema involving rejection will become depressed when a partner leaves him or her

Original Meeting and Assessment Time

- A 23 year old Jewish-American woman comes to the office to see me. After my initial introduction, I ask her what she needs from me today and what would she describe as her primary need.

- She answers, somewhat tearfully, that she is worried about how to manage her stress. “I don’t want to be like my Mother. She has been depressed her entire life and never got help.”
Continued

- She continues to talk about her current situation and says she had dropped out of school just recently due to stress. Her affect is flat and she is tearful throughout the interview. She mentions (with questioning) that she has had periodic times of “thinking of wanting to not be around” but has no plans or intent of pursuing these thoughts.

Continued

- Her social support primarily consists of her fiancé and some female friends who she has known since middle school. She is not particularly close to her Father, saying that he has never been supportive of her. In addition, he recently re-married a much younger woman (Aged 28, Father is 70 yrs.) and is “spending money like mad. He never would buy my Mother or us anything. I do not understand why he is acting like this. My Mother is even more depressed about this circumstance.” The client also reports that her parents divorced when she was in the 3rd grade.
Continued

- The client reports no physical diagnoses. She is clean but somewhat disheveled in her overall appearance. He is appropriate in affect, shows no indication of psychosis but is slow to respond to questions, even though her responses are appropriate. She is slightly overweight and mentions this as a concern for her.

Continued

- At this point, what is your impression of this client?
- What initial diagnoses might you consider? Consider all of the Axes I - V
- Are there interventions that you would consider regarding counseling techniques?
- Are there medications that you might consider using?
- Are there other issues that you see as meaningful to consider?
Depression References


Treatment Plan

• What members of the transdisciplinary team are involved?
• How do you, as a PMH nurse facilitate the use of CBT & RET within your clinical setting?
• Reinforce/Implement CBT and RET interventions included in the treatment plan.
• Read the treatment plan & reinforce items within your scope of practice
• Chart to the treatment plan.
• If the treatment Plan indicates “client will be redirected using CBT techniques” you may chart something like, “client was redirected four times this evening.”

CBT: Sessions

• *Identify and changing maladaptive thoughts*

• First sessions: therapist explains cognitive theory of emotional disorders (negative cognitions contribute to distress)
• Middle Sessions: Client is taught to identify, evaluate and replace negative automatic thoughts were more positive cognitions
• Therapist is a collaborator
• Final Sessions: solidify gains, focus on prevention of recurrence
CBT and RET

• Identifying Assumptions and Core Beliefs
• “If..., then...”
• Downward arrow
  - If this thought is true, what’s so bad about that?
  - What’s the worst part about that?
  - What does it mean to you? About you?

Relapse Prevention

• Solidify gains: broaden range of identified negative thoughts and strengthen more positive cognitions
• Anticipate future stressful life events that might trigger a future depression and role play more adaptive responses
Evaluation of CBT

Nursing Clinical Reasoning Processes

Practice the techniques yourself!

CBT & RET References