07 - 28.7 Cognitive Therapy

28.7 Cognitive Therapy

REFERENCES Enger T, Gruzelier JH. EEG biofeedback of low beta band components: Frequency-specific effects on variables of attention and event-related brain potentials. Clin Neurophysiol. 2004;115:131–139. Enriquez-Geppert S, Huster RJ, Herrmann CS. Boosting brain functions: Improving executive functions with behavioral training, neurostimulation, and neurofeedback. Int J Psychophysiol. 2013;88(1):1–16. Jacob RG, Pelham WE. Behavior therapy. In: Sadock BJ, Sadock VA, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 8th ed. Philadelphia: Lippincott Williams & Wilkins; 2005:2498. Manko G, Olszewski H, Krawczynski M, Tlokinski W. Evaluation of differentiated neurotherapy programs for patients recovering from severe TBI and long term coma. Acta Neuropsychol. 2013;11(1):9–18. Mitani S, Fujita M, Sakamoto S, Shirakawa T. Effect of autogenic training on cardiac autonomic nervous activity in highrisk fire service workers for posttraumatic stress disorder. J Psychosom Res. 2006;60(5):439–444. Nanke A, Rief W. Biofeedback in somatoform disorders and related syndromes. Curr Opin Psychiatry. 2004;17(2):133–138. Othmer S, Pollock V, Miller N. The subjective response to neurofeedback. In: Earleywine M, ed. Mind-Altering Drugs: The Science of Subjective Experience. New York: Oxford University Press; 2005:345. Purohit MP, Wells RE, Zafonte R, Davis RB, Yeh GY, Phillips RS. Neuropsychiatry symptoms and the use of mind-body therapies. J Clin Psychiatry. 2013; 74(6):e520–e526. Ritz T, Dahme B, Roth WT. Behavioral interventions in asthma: Biofeedback techniques. J Psychosom Res. 2004;56(6):711– 720. Schoenberg PL, David AS. Biofeedback for psychiatric disorders: A systematic review. Appl Psychophysiol Biofeedback. 2014;39(2):109–135. Schwartz MS, Andrasik F, eds. Biofeedback: A Practitioner's Guide. 3rd ed. New York: Guilford; 2003. Scott WC, Kaiser D, Othmer S, Sideroff SI. Effects of an EEG biofeedback protocol on a mixed substance abusing population. Am J Drug Alcohol Abuse. 2005;31(3):455–469. Seo JT, Choe JH, Lee WS, Kim KH. Efficacy of functional electrical stimulation-biofeedback with sexual cognitivebehavioral therapy as treatment of vaginismus. Urology. 2005;66(1):77–81. Thornton KE, Carmody DP. Electroencephalogram biofeedback for reading disability and traumatic brain injury. Child Adolesc Psychiatric Clin North Am. 2005;14:137–162. Yucha C, Gilbert C. Evidence-Based Practice in Biofeedback and Neurofeedback. Wheat Ridge, CO: Association for Applied Psychophysiology and Biofeedback; 2004. 28.7 Cognitive Therapy A central feature of the cognitive theory of emotional disorders is its emphasis on the psychological significance of people's beliefs about themselves, their personal world (including the people in their lives), and their future—the "cognitive triad." When people experience excessive, maladaptive emotional distress, it is linked to their problematic, stereotypic, biased interpretations pertinent to this cognitive triad of self, world, and future. For example, clinically depressed patients may be prone to believe that they are incapable and helpless and to view others as being judgmental and critical and the future as being bleak and unrewarding.

Similarly, patients with anxiety disorders may be apt to see themselves as highly vulnerable, others as more capable, and the future as likely to be characterized by personal disasters.

Although the patient's viewpoints are flawed and dysfunctional, they nonetheless tend to be perpetuated by cognitive processes that maintain them. Cognitive therapy is a short-term, structured therapy that uses active collaboration between patient and therapist to achieve its therapeutic goals, which are oriented toward current problems and their resolution. Cognitive therapy is used with depression, panic disorder, obsessive-compulsive disorder, personality disorders, and somatoform disorders. Therapy is usually conducted on an individual basis, although group methods are sometimes helpful. A therapist may also prescribe drugs in conjunction with therapy. The treatment of depression can serve as a paradigm of the cognitive approach. Cognitive therapy assumes that perception and experiencing, in general, are active processes that involve both inspective and introspective data. The patient's cognitions represent a synthesis of internal and external stimuli. The way persons appraise a situation is generally evident in their cognitions (thoughts and visual images). Those cognitions constitute their stream of consciousness or phenomenal field, which reflects their configuration of themselves, their world, their past, and their future. Alterations in the content of their underlying cognitive structures affect their affective state and behavioral pattern. Through psychological therapy, patients can become aware of their cognitive distortions. Correction of faulty dysfunctional constructs can lead to clinical improvement. COGNITIVE THEORY OF DEPRESSION According to the cognitive theory of depression, cognitive dysfunctions are the core of depression, and affective and physical changes and other associated features of depression are consequences of cognitive dysfunctions. For example, apathy and low energy result from a person's expectation of failure in all areas. Similarly, paralysis of will stems from a person's pessimism and feelings of hopelessness. From a cognitive perspective, depression can be explained by the cognitive triad, which explains that negative thoughts are about the self, the world, and the future. The goal of therapy is to alleviate depression and to prevent its recurrence by helping patients to identify and test negative cognitions, to develop alternative and more flexible schemas, and to rehearse both new cognitive and behavioral responses. Changing the way a person thinks can alleviate the psychiatric disorder. STRATEGIES AND TECHNIQUES Therapy is relatively short and lasts about 25 weeks. If a patient does not improve in this time, the diagnosis should be reevaluated. Maintenance therapy can be carried out over years. As with other psychotherapies, therapists' attributes are important to successful therapy. Therapists must exude warmth, understand the life experience of each patient, and be genuine and honest with themselves and with their patients. They must be able to relate skillfully and interactively with their patients. Cognitive therapists set the agenda at the beginning of each session, assign homework to be performed between sessions, and teach new skills. Therapist and patient collaborate

actively (Table 28.7-1). The three components of cognitive therapy are didactic aspects, cognitive techniques, and behavioral techniques. Table 28.7-1 Cognitive Psychotherapy Didactic Aspects The therapy's didactic aspects include explaining to patients the cognitive triad, schemas, and faulty logic. Therapists must tell patients that they will formulate hypotheses together and test them over the course of the treatment. Cognitive therapy requires a full explanation of the relation between depression and thinking, affect, and behavior, as well as the rationale for all aspects of treatment. This explanation contrasts with psychoanalytically oriented therapies, which require little explanation. Cognitive Techniques The therapy's cognitive approach includes four processes: eliciting automatic thoughts, testing automatic thoughts, identifying maladaptive underlying

assumptions, and testing the validity of maladaptive assumptions. Eliciting Automatic Thoughts. Automatic thoughts, also called cognitive distortions, are cognitions that intervene between external events and a person's emotional reaction to the event. For example, the belief that "people will laugh at me when they see how badly I bowl" is an automatic thought that occurs to someone who has been asked to go bowling and responds negatively. Another example is the thought "She doesn't like me" when someone passes in the hall without saying "Hello." Every psychopathological disorder has its own specific cognitive profile of distorted thought, which, if known, provides a framework for specific cognitive interventions (Table 28.72).

Table 28.7-2 Cognitive Profile of Psychiatric Disorders Testing Automatic Thoughts. Acting as a teacher, a therapist helps a patient test the validity of automatic thoughts. The goal is to encourage the patient to reject inaccurate or exaggerated automatic thoughts after careful examination. Patients often blame themselves when things that are outside their control go awry. The therapist reviews the entire situation with the patient and helps reassign the blame or cause of the unpleasant events. Generating alternative explanations for events is another way of undermining inaccurate and distorted automatic thoughts. Identifying Maladaptive Assumptions. As the patient and therapist continue to identify automatic thoughts, patterns usually become apparent. The patterns represent rules or maladaptive general assumptions that guide a patient's life. Samples of such rules are "In order to be happy, I must be perfect" and "If anyone doesn't like me, I'm not lovable." Such rules inevitably lead to disappointments and failure and, ultimately, to depression (Fig. 28.7-1). Testing the Validity of Maladaptive Assumptions. Testing the accuracy of maladaptive assumptions is similar to testing the validity of automatic thoughts. In a particularly effective test, therapists ask patients to defend the validity of their assumptions. For example, patients may state that they should always work up to their potential, and a therapist may ask "Why is that so important to you?" Table 28.7-3 gives examples of some interventions designed to elicit, identify, test, and correct the cognitive distortions that lead to depressive and other painful affects. Table 28.7-3 Cognitive Errors Derived from Assumptions

A woman presented for therapy with anger control problems. She had sent a slew of hostile voicemail and e-mail messages to a colleague, had alienated her neighbors with her complaints about noise, and had been asked to leave her bowling league after two physical altercations with members of other teams. A careful review of the patient's thoughts and beliefs surrounding these situations revealed a common denominator of a sense of mistrust and entitlement. In each situation, she believed that the persons who were the objects of her anger had gone out of their way to mistreat her. Furthermore, she had an exaggerated sense of self-importance represented by beliefs such as, "Nobody has the right to treat me that way," "I shouldn't have to deal with these people and their stupidity," and "I have to show them they can't ever push me around." To this patient, her anger was justified, as she was trying to defend herself from the misbehavior of others. However, to the outside observer, the patient was a "loose cannon" who took offense at the drop of a hat and whose behavior was outrageous and indefensible. In therapy, the patient at first was not open to viewing her anger problem in the manner just described. However, as she learned to recognize the activation of her schemas of mistrust and entitlement, she became more willing to consider ways in which she could modify her viewpoints and behaviors. This positive change was facilitated by the therapist's empathic responses to the patient's more credible stories of mistreatment she had received from her family, whose abusive behavior gave her the message that she should never trust anyone and that she should never put up with being mistreated again.

(Courtesy of C. F. Newman, Ph.D., and A. T. Beck, M.D.)

FIGURE 28.1 Sample automatic thought record. Behavioral Techniques Behavioral and cognitive techniques go hand in hand; behavioral techniques test and change maladaptive and inaccurate cognitions. The overall purposes of such techniques are to help patients understand the inaccuracy of their cognitive assumptions and learn new strategies and ways of dealing with issues. Among the behavioral techniques in cognitive therapy are scheduling activities, mastery and pleasure, graded task assignments, cognitive rehearsal, self-reliance training, role playing, and diversion techniques. One of the first things done in therapy is to schedule activities on an hourly basis. Patients keep records of the activities and review them with the therapist. In addition to scheduling activities, patients are asked to rate the amount of mastery and pleasure their activities bring them. Patients are often surprised to learn that they have much more mastery of activities and enjoy them more than they had thought. To simplify the situation and allow miniaccomplishments, therapists often break tasks into subtasks, as in graded task assignments, to show patients that they can succeed. In cognitive rehearsal, patients imagine and rehearse the various steps in meeting and mastering a challenge. Patients (especially inpatients) are encouraged to become self-reliant by doing such

simple things as making their own beds, doing their own shopping, and preparing their own meals. This process is called self-reliance training. Role playing is a particularly powerful and useful technique to elicit automatic thoughts and to learn new behaviors. Diversion techniques are useful in helping patients get through difficult times and include physical activity, social contact, work, play, and visual imagery. Imagery or thought stoppage can treat impulsive or obsessive behavior. For instance, patients imagine a stop sign with a police officer nearby or another image that evokes inhibition at the same time that they recognize an impulse or obsession that is alien to the ego. Similarly, obesity can be treated by having patients visualize themselves as thin, athletic, trim, and well muscled, and then training them to evoke this image whenever they have an urge to eat. Hypnosis or autogenic training can enhance such imagery. In a technique called guided imagery, therapists encourage patients to have fantasies that can be interpreted as wish fulfillments or attempts to master disturbing affects or impulses.

EFFICACY Cognitive therapy can be used alone in the treatment of mild to moderate depressive disorders or in conjunction with antidepressant medication for major depressive disorder. Studies have clearly shown that cognitive therapy is effective and in some cases is superior or equal to medication alone. It is one of the most useful psychotherapeutic interventions currently available for depressive disorders, and it shows promise in the treatment of other disorders. Cognitive therapy has also been studied as a way of increasing compliance with lithium (Eskalith) prescription by patients with bipolar I disorder and as an adjunct in treating withdrawal from heroin. Table 28.7-4 outlines Beck’s criteria for determining when cognitive therapy is indicated. Table 28.7-4 Indications for Cognitive Therapy

REFERENCES Beck AT, Freeman A, Davis DD. Cognitive Therapy of Personality Disorders. 2nd ed. New York: Guilford; 2003. Coelho HF, Canter PH, Ernst E. Mindfulness-based cognitive therapy: Evaluating current evidence and informing future research. Psychol Conscious Theory Res Pract. 2013;1(Suppl):97–107 Dobson KS. The science of CBT: Toward a metacognitive model of change? Behav Ther. 2013;44(2):224–227. Ehde DM, Dillworth TM, Turner JA. Cognitive-behavioral therapy for individuals with chronic pain: Efficacy, innovations, and directions for research. Am Psychol.

2014;69(2):153. Hollon SD. Does cognitive therapy have an enduring effect? Cognit Ther Res. 2003;27:71–75. Lam DH, Watkins ER, Hayward P, Bright J, Wright K, Kerr N, Parr-Davis G, Pak S. A randomized controlled study of cognitive therapy for relapse prevention for bipolar affective disorder: Outcome of the first year. Arch Gen Psychiatry. 2003;60:145–152. Leahy RL, ed. Contemporary Cognitive Therapy: Theory, Research, and Practice. New York: Guilford; 2004.

Revision #1
Created 2026-01-04 19:51:31 UTC by Omar Ayman
Updated 2026-01-04 19:51:31 UTC by Omar Ayman