CBT FOR ANXIETY AND DEPRESSION

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KNOWLEDGE AND PRACTICE OF CBT?

- What do you know about CBT?
- What sorts of things do you do already?
- Are there any particular things about CBT that you are interested in?
AGENDA

Part One
▪ A bit of talk – theory, what it looks like, who is it effective for, etc

Part Two
▪ A bit of skills – some interventions you could try with your patients
WHAT IS CBT?
WHAT IS CBT?

CBT was developed at the University of Pennsylvania by Aaron T. Beck in the early 1960s as a **brief, present-focused** therapy for **depression**

**CBT defined:**
- “A structured short-term, present orientated psychotherapy for depression, directed toward solving current problems and modifying dysfunctional thinking and behaviour.” (Beck, 1964)
COGNITIVE BEHAVIOUR THERAPY

• Build on the traditions of previous therapies
• But theoretically moved away from the ideas of a collective unconscious
• Therapeutically emphasises understanding the past but focusing on the present and the future
Cognitive Behaviour Therapy

• CBT is a conceptual paradigm rather than a discrete set of techniques for specific disorders.
• CBT teaches clients to identify, evaluate, and change dysfunctional (unhelpful) thinking patterns to facilitate mood and behaviour changes.
WHAT COGNITIVE THERAPY IS NOT

Unemotional
Disinterested in the past
Mechanical
Superficial
Cookbook
EFFICACY OF CBT

CBT now has demonstrated efficacy in the treatment of:
- Depression
- Anxiety disorders – full range
- Drug and Alcohol abuse
- Psychotic disorders
- Bipolar disorder
- Eating Disorders
- Personality disorders
- Insomnia
- Medical problems (e.g. chronic pain, fatigue, cancer, etc)
- Clinical Perfectionism
- (weight management)
WHO IS CBT FOR?

And is used with

- Adults
- Children
- Adolescents
- Older adults
- Couples
- Groups
WHAT DOES IT LOOK LIKE?

- 4 – 20 sessions (depending on the disorder/problems)
- Key elements of every session
  - Agenda
  - Collaborative
  - Shared understanding of the problem
  - Homework / “between session activity” / action plan
  - Feedback
- Sessions start close together, and eventually are months apart
A LITTLE BIT OF THEORY
PERSON 1
PERSON 2
PERSON 4
BASIC COGNITIVE PRINCIPLE

Common Sense Model

Event ➞ Emotion

Cognitive Model

Event ➞ Cognition ➞ Emotion
BASIC COGNITIVE PRINCIPLE

Sees a spider

Spiders are scary

Fear

Anxious Example

Makes a mistake

I can’t do this

I’m useless

Hopeless

Depressive Example
BASIC COGNITIVE PRINCIPLE

Surprise/Anxious Example

Sees a dirty great spider on the screen → I wasn’t expecting that → Surprise

Irritation Example

Sees a dirty great spider on the screen → I hate surprises → Annoyed
Men are disturbed not by things, but by the view which they take of them

Epictetus, 135-55AD
HOW MIGHT THIS RELATE TO PRESCRIBING?
BASIC COGNITIVE PRINCIPLE APPLIED TO TAKING MEDICATION

Common Sense Model

I was unhappy and I took some meds → Less unhappy
I was unhappy and I took some meds

IT MUST BE BECAUSE OF THE MEDICATION (it is not about any efforts made on my part)

Less unhappy
WHY DELAYING MEDICATION CAN ASSIST WITH THERAPY

- Attributions
- When it works (esp. benzodiazepines)
CONCEPTUAL FRAMEWORK
CONCEPTUAL FRAMEWORK

- CBT Theory and Guiding Principles
- Therapeutic relationship
- Conceptualisation, Measurement, Assessment
- Structure of CT
- Specific Intervention Techniques
PHASES OF THERAPY
PHASES OF CBT

Phase 1: Assessment and Understanding
  - Diagnosis
  - Problem List
Phase 2: Sleep
Phase 3: Behavioural/Physical Activation
Phase 4: Thinking
Phase 5: Beliefs
PHASE ONE

Understanding
CONCEPTUALISING

Use the CBT model to develop

- Description of the current problem
- Account of why and how these problems might have developed
- An analysis of the key maintaining processes hypothesised to keep the problems going
UNDERSTANDING THE CLIENT AND THEIR PROBLEM(S)

Maintaining Cycles
- Keep the problem going (or worsen it)
- Can seem like vicious cycles or feedback loops
- Can be characteristic of certain conditions
ESCAPE/AVOIDANCE - ANXIETY

Fear
Fear of situation/object

Escape/Avoidance
Tries to avoid feared object, or escape asap

No change in fear beliefs
Client does not learn coping strategies or expose beliefs to disconfirmation
REDUCTION IN ACTIVITY

Depressed mood

Loss of Positive Rewards
Loss of activities that used to give one pleasure, achievement, or social acceptance

Negative thoughts
Activity seen as pointless, not enjoyable, too demanding, etc

Reduced Activity
General reduction of activity, social withdrawal, etc
THE 5-PART MODEL
CBT therapists look at the relationship between **thoughts, behaviour, emotion, physiology and environment** to understand the origin and nature of a client’s problems.

All five areas are interconnected, each influencing each other.

Intervention can be targeted at any of the five areas.
THE 5 PART MODEL

- Situation
- Thoughts
- Physiology
- Emotion
- Behaviour
MAJOR DEPRESSIVE DISORDER

Depressed mood and/or loss of pleasure

Plus 5 of:

- Appetite changes
- Sleep changes
- Psychomotor changes
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Diminished ability to think or concentrate
- Recurrent thoughts of death
Situation
Waiting for the bus

Emotion
Anxious

Physiology
Stomach fluttering

Thoughts
- Have I missed the bus?
- I don't have anything interesting to say.
- I don't want them uncomfortable.
- I can be annoying.
- I don't want to appear clingy or annoying.
- I don't want to disturb their thoughts.
- I don't come across as friendly.

Behavior
- Over-anxious schedule
- Mum asked me to call.
- Avoided talking to person.
- Prepared to prepare food.
THE 5 PART MODEL - INTERVENING

- Situation
  - Controlled Breathing
    - PMR
    - Guided Imagery
  - Physiology
    - Activity Scheduling
    - Activation
    - Graded Task Assign
  - Behaviour
  - Thoughts
    - Thought Record
  - Emotion
    - Mood Monitoring
  - Problem Solving

Thoughts

Emotion
PRESENTING PROBLEMS
PRESENTING PROBLEMS CONNECTED TO ANXIETY AND DEPRESSION

- Sleep
- Anxious feelings (and associated physiology)
- Low mood
- No engagement in enjoyable/rewarding activity
- Low socialising
- Not exercising
PRESENTING PROBLEMS

• A ssessment
• R ationale
• I ntervention
• P rescription
PHASE TWO
Sleep
Assessment:
Determine what the sleep problem is (quality, quantity, early/middle/late waking, bedtime behaviours) plus what is the thinking connected with sleep

Rationale:
Sleep has a huge impact on mood, energy, physical functioning, etc, etc
SLEEP

Intervention:

Education about sleep, sleep hygiene and stimulus control

https://www.pharmac.govt.nz/seminars/seminar-resources/
SLEEP

Prescription:
• What exactly are they going to do in the meantime?
• When will they do it?
• What is the frequency, intensity, duration of what they are being asked to do?
• What obstacles might they anticipate in completing the task/prescription/homework? How might they handle these?
• FOLLOW UP
Prescription/Homework

What:

How often:

When:

Obstacles and how handle these:

Next Appointment Time:
SLEEP

Apps:
- Sleepio (www.sleepio.com)
- Sleep cycle (www.sleepcycle.com)
PHASE THREE

Behavioural/Physical Interventions
BEHAVIOURAL INTERVENTIONS

- Controlled breathing
- Relaxation
- Behavioural activation
CONTROLLED BREATHING AND MINDFULNESS

Assessment:
Determine as many of the physiological symptoms that are being experienced (that are likely to be consistent with anxiety)

Rationale:
In anxiety shallow breathing is likely exacerbating the response, so you need an intervention to manage that
CONTROLLED BREATHING AND MINDFULNESS

Intervention:
Psychoeducation about anxiety
Choose one method of controlled breathing and stick to that
CONTROLLED BREATHING AND MINDFULNESS

Prescription:

• What exactly are they going to do in the meantime?

• When will they do it?

• What is the frequency, intensity, duration of what they are being asked to do?

• What obstacles might they anticipate in completing the task/prescription/homework? How might they handle these?

• FOLLOW UP
Prescription/Homework

What:

How often:

When:

Obstacles and how handle these:

Next Appointment Time:
CONTROLLED BREATHING AND MINDFULNESS

Apps:

- *Calm* ([www.calm.com](http://www.calm.com)) (and meditation)

- *Breathe* ([www.stopbreathethink.org](http://www.stopbreathethink.org)) (and meditation, and other)

- *Headspace* ([www.headspace.com](http://www.headspace.com)) (meditation and mindfulness)
PROGRESSIVE MUSCLE RELAXATION

Assessment:
Same as controlled breathing

Rationale:
Same as for controlled breathing
PROGRESSIVE MUSCLE RELAXATION

Intervention:
Psychoeducation about anxiety
Choose one method of progressive muscle relaxation and stick to that
PROGRESSIVE MUSCLE RELAXATION

Write it down, or get them to write it down

Prescription:

• What exactly are they going to do in the meantime?
• When will they do it?
• What is the frequency, intensity, duration of what they are being asked to do?
• What obstacles might they anticipate in completing the task/prescription/homework? How might they handle these?
• FOLLOW UP
Prescription/Homework

What:

How often:

When:

Obstacles and how handle these:

Next Appointment Time:
PROGRESSIVE MUSCLE RELAXATION

Apps:
https://www.thinkpacifica.com/
**BEHAVIOURAL ACTIVATION**

**Assessment:**

What are they currently up to in terms of activity? Think about ADLs as well as enjoyable or rewarding activity

**Rationale:**

Engagement in activity directly impacts on the mood*
BEHAVIOURAL ACTIVATION

Intervention:
1 – determine what activities are enjoyable
2 – plan to undertake enjoyable activities – create a schedule
3 – determine the impact on mood when undertake EA
BEHAVIOURAL ACTIVATION

Prescription:

• What exactly are they going to do in the meantime?

• When will they do it?

• What is the frequency, intensity, duration of what they are being asked to do?

• What obstacles might they anticipate in completing the task/prescription/homework? How might they handle these?

• FOLLOW UP
Prescription/Homework

What:

How often:

When:

Obstacles and how handle these:

Next Appointment Time:
BEHAVIOURAL ACTIVATION

Apps:
Mood Coach
THREE LEVELS OF THOUGHT

Automatic thoughts

- Moment to moment, unplanned that go through our head during any given day
- Can be words, images, or memories
THREE LEVELS OF THOUGHT

Underlying assumptions

- Cross situation rules or beliefs that guide our lives and behaviour
- Often include “shoulds” and conditional statements “if ... then ...”
THREE LEVELS OF THOUGHT

Schemas/Core Beliefs

- “screens or filters that process and code stimuli” (Beck et al, 1979)
- Absolutistic beliefs about the self, others and the world
  - Self: I’m unlikeable, a failure, defective
  - Others: Are critical, untrustworthy
  - World: a dangerous place
THREE LEVELS OF THOUGHT

Automatic Thoughts
- I won’t have fun at the party

Underlying Assumption
- If ... then

Core Belief
- I’m ...
THREE LEVELS OF THOUGHT

Automatic Thoughts
• I won’t have fun at the party

Underlying Assumption
• If people meet me then they won’t like me

Core Belief
• I’m unlovable
LEVELS OF THOUGHT

Automatic Thoughts
• I always stuff up my exams

Underlying Assumption
• If I don’t pass then people will think I’m stupid

Core Belief
• I’m a failure
LEVELS OF THOUGHT

- **Automatic Thoughts**
  - This always happens to me

- **Underlying Assumption**
  - If I make an effort it doesn’t help so (then) I may as well not try

- **Core Belief**
  - I’m useless
  - The world is a difficult place
PHASE FIVE
Beliefs
REVIEW
CONCEPTUAL FRAMEWORK

- CBT Theory and Guiding Principles
- Therapeutic relationship
- Assessment, Measurement, Conceptualisation
- Structure of CT
- Specific Intervention Techniques
BASIC COGNITIVE PRINCIPLE

Common Sense Model

Event → Emotion

Cognitive Model

Event → Cognition → Emotion
Prescription:
• What exactly are they going to do in the meantime?
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• FOLLOW UP
FEEDBACK AND QUESTIONS
RESOURCES

Mind over Mood (2nd ed., 2016) – Greenberg and Padesky

An Introduction to Cognitive Behaviour Therapy (3rd ed., 2016) – Kennerley, Kirk & Westbrook

www.beckinstitute.org – online CBT courses for health professionals

Post-Graduate Diploma in CBT at Massey University (2 years part-time)
SELF HELP RESOURCES

www.beatingtheblues.co.nz
www.thelowdown.co.nz
http://www.depression.org.nz/waythrough/self+help
www.calm.auckland.ac.nz
http://www.getselfhelp.co.uk/
www.fiveareareas.com
CONCEPTUALISING (J. BECK)

- Relevant Childhood Data
- Core Belief(s)
- Conditional Assumptions/ Beliefs
- Compensatory Strategies
CONCEPTUALISING (WESTBROOK)

Figure 4.12 A template formulation
Given the lack of nurturance, attention, affection, and interest that Sally received growing up it makes sense that she would see herself as not important and nobody. As a child she was able to get some attention from her teachers when she performed well academically, which set the precedent for achievement-based satisfaction, however, this achievement was somewhat undermined by her parents lack of interest and her sister’s open criticism. Sally struggled with friendships at school and had some ‘unhelpful’ dating relationships (dating men because they were “cool”) which further reinforced her view of herself. In order to avoid triggering this view she overcompensated with unrelenting standards, controls, and emotional avoidance, skills that lost their effectiveness in the face of (uncontrollable) infertility and mounting work pressures. This also led her to see her future as hopeless and not what she had planned.
Things identified: 
- disappointment
- hurt
- rejection
- resentment
- betrayal

Environment:
- distant from parents
- little contact with father
- strict
- religious
- limited emotional expression
- bullied
- picked on

Rule:
- If people love each other then they should always be there for each other, no matter what
  ➞ high expectations of others
  ➞ often disappointed
  ➞ unforgiving when others make mistakes

Belief: Unloveability

Depressed
- if people won't help me, then I must be unloveable

Behaviour:
- won't ask for help (so won't trigger belief)

Thoughts:
- selectively attend to info that supports core belief
  ➞ only see situations where people won't help

Mood:
- depressed

Manic
- if people help me, I must be loveable

Behaviour:
- repeatedly ask for help (to affirm belief)
  ➞ initially usually meets with success
  ➞ but generally declines

Thoughts:
- actively ignore or suppress any evidence that no longer receiving assistance

Mood:
- elevated

Protective:
- intelligence
- resourcefulness
- excellent work history
- strong work ethic
- commitment to address issues
- no hospital in > 1yr.

Recommendations:
- use coping skills
  ➢ second term in coping skills group
  ➢ outside counselling
  ➢ bipolar support group.