

Cognitive behavioural therapy (CBT) – case studies

Psychotherapia poznawczo-behawioralna – opis przypadków

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Słowa kluczowe: psychotherapia poznawczo-behawioralna, relacja, zmiana, pacjent, myśli automatyczne, schematy poznawcze, cele.

Abstract

The objective of the present study is to further elucidate the specifics cognitive behavioural therapy (CBT) based on the treatment of 2 patients. The theoretical background of the therapy is based on the idea that the learning processes determine behaviour (behavioural therapy), acquisition and consolidation of beliefs and view of the world (cognitive therapy). The CBT is short-term (usually 12–20 weekly sessions). It assumes close links between the patient's thoughts (about self, the world and the future) and his/her emotions, behaviour and physiology. The patient's work in between sessions consists in observation of their own thoughts, behaviours, and emotions, and introduction of changes within the scope of their thoughts and behaviours. The goal of cognitive behavioural therapy is autonomy and independence of a patient, attainment of the patient's objectives, and remedying the most important problems of the patient. The therapist should be active, warm and empathic. Cognitive behavioural therapy is structured and active. Between sessions, the patient receives homework assignments to complete. During therapy, information is collected by experiments and verification of hypotheses. It should be emphasized that for changes to occur in the process of psychotherapy it is necessary to establish a strong therapeutic alliance.

Streszczenie

Celem niniejszego artykułu jest przybliżenie specyfiki psychoterapii poznawczo-behawioralnej (TPB) na podstawie terapii 2 pacjentek. Podłoże teoretyczne terapii stanowi to, że procesy uczenia się determinują zachowanie (terapia behawioralna), nabywanie oraz utrwalanie przekonań i sposobu widzenia świata (terapia poznawcza). Psychotherapia poznawczo-behawioralna jest krótkoterminowa (zazwyczaj 12–20 sesji cotygodniowych). Zakłada dużą zależność pomiędzy myślami pacjenta (o sobie, świecie i przyszłości) a jego emocjami, zachowaniem i fizjologią. Praca pacjenta pomiędzy sesjami polega na obserwacji swoich myśli, zachowań, emocji oraz wprowadzaniu zmian w zakresie swoich myśli i zachowań. Celem TPB jest niezależność i samodzielność pacjenta, realizacja jego celów i zaradzenie najistotniejszym problemom. Terapeuta powinien być aktywny, ciepły i empatyczny. Terapia poznawczo-behawioralna jest ustrukturalizowana i aktywna. Pomiędzy sesjami pacjent otrzymuje prace domowe do wykonania. Podczas terapii informacje są zbierane przez eksperymenty oraz weryfikację hipotez. Należy podkreślić fakt, że aby nastąpiły zmiany w procesie psychoterapii, konieczne jest zbudowanie silnego przymierza terapeutycznego.

Introduction

The objective of the present study is to characterize cognitive behavioural therapy and present case studies of 2 patients.

The theoretical background of therapy is based on the idea that the learning processes determine behaviour (behavioural therapy), acquisition and consolidation of beliefs and view of the world (cognitive therapy) [1].

In order to explain the concept of cognitive behavioural therapy one should first look closely at the

term 'psychotherapy'. Psychotherapy is the process of treatment of the soul (from Greek *psyche* – soul, *therapein* – to treat). According to Józef Koziński, psychotherapy is a systematic and purposeful method of modification and correction of personality, and treatment of emotional disorders using psychological measures, such as free flow of words, discourse, mimicry, emotional bond with a patient or self-learning of new skills [2]. Thus, according to Koziński, the most important instrument in psychotherapy is conversation (words) and an emotional bond with a patient. In

turn, Rogers (1991 after [3]) defines psychotherapy as the way of being with another person which favours healthy changes and facilitates development. He assumes that: 'It is that the individual has within himself or herself vast resources for self-understanding, for altering his or her self-concept, attitudes and self-directed behavior – and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided. The therapist senses accurately the feeling and personal meanings that the client is experiencing and communicates this acceptant understanding to the client' [4].

'He assumes that an individual has great skills of self-understanding and establishing changes in the way of being and behaviour, and a specific relation with another person creates the best conditions to reveal these skills and turn them into reality. Its specific character consists in that a therapist or other person providing assistance experiences himself or herself as he or she is, shows deep sensitivity and understanding towards the other person, is concerned about him or her and communicates all these feelings'.

Rogers emphasizes that the specific way of being with another person is most important in psychotherapy when the therapist believes that the patient possesses capabilities for self-understanding and introduction of changes in various spheres of their own life. Thus, the patient introduces changes against the background of emphatic relations with the therapist.

Therefore, it may be summed up that what differentiates psychotherapy from psychological assistance is the goal. The goal of psychotherapy is for the patient to attain insight, and consequently the change which boils down to the removal of disorders in experiencing, disorders in the functions of the body organs, and widely understood behaviour of an individual, as well as the causes of these disorders [3]. The goal of interaction in psychotherapy is for the patient to attain an insight, making him or her aware of experiences and psychological processes of which he or she has been previously unaware, an alteration in experiencing and behaviour for the patient to cope with intrapsychological and external tensions and problems [3].

Patients who participate in the process of psychotherapy usually perceive the necessity for such assistance, and wish to implement changes in their life in order to be able to function better. It is noteworthy that there are some patients who have received a suggestion to participate in psychotherapy from another specialist (e.g. a physician); however, they are not motivated to make changes in their life and then, even after the patient obtains an insight, they are not motivated to make changes in their lives.

The term 'cognitive psychotherapy' is worth considering. Cognitive psychotherapy is derived from the cognitive model of development of mental disorders (Danion, Weingartner and Singer, 1996; after [1]). This

model assumes that the common feature of emotional problems and mental disorders is the occurrence of characteristic automatic thoughts, schemes and cognitive distortions. Cognitive therapy was developed by Aaron T. Beck at the University of Pennsylvania during the 1960s as a systematized, short-term and future-oriented form of psychotherapy for depression. It was biased towards solving current problems, and change of non-functional ways of thinking and behaviour (Beck, 1964, after [5]). Thus, the cognitive change would concern the overall cognitive contents – beliefs, judgements, expectations, and cognitive processes – deduction, cognitive distortions [1]. Popiel and Pragłowska [1] define an effective cognitive therapy as a complex process consisting of several stages. At the first stage, the patient must become aware of their own thoughts. At the second stage, he or she must perceive the relations between thoughts and problematic emotions and behaviours. The third stage is the verification of judgements, and replacement of dysfunctional ways of thinking by those which are more adequate. At the fourth stage, the feedback information is important, concerning which of the alterations result in better functioning of the patient, and verification of beliefs in real life.

The term 'behavioural psychotherapy' is based on the concept and processes of learning according to the behavioural model of human functioning. According to this model, an individual learns maladaptive behaviours based on their own experiences and observations. Therefore, strengthening of responses to specified stimuli is important [1]. In this way, behavioural therapists work on change of undesirable behaviours and learning the behaviours which are desired. Methods of therapy are: extinguishing and/or inhibition of dysfunctional behaviours by the use of positive and negative reinforcement according to the models of classical or instrumental conditioning, together with the modelling of desirable behaviours which assume the process of learning by observation. Testing the effectiveness of new behaviours takes place by behavioural experiments, which are performed by the patient in real life [1].

Summing up, it may be presumed that cognitive behavioural therapy combines the cognitive and behavioural approaches. It uses and combines the methods and techniques of both cognitive and behavioural work. However, in order to attain a change in the functioning of an individual the cognitive change must take place in the patient – a change at the level of thoughts and beliefs. Cognitive behavioural therapy could identify and modify unhelpful thinking styles and maladaptive behaviours [6, 7]. Cognitive behavioural therapy is helpful in treatment of depression, anxiety and psychiatric disorders and chronic illnesses such as chronic obstructive pulmonary disease, diabetes [8] and cancer [9].

Cognitive behavioural therapy is a short-term therapy (usually 12–30 weekly sessions). This psychotherapy is targeted at solving the current problems of the patient; thus it is focused on ‘what is here and now’. It assumes a good relationship between thoughts (about the self, the world, others, the past, the present and the future), emotions and physiological experiences.

During therapy, the therapist is directive, whereas the patient should be active. The patient’s work between the sessions consists in completion of homework assignments (tasks) which may consist in e.g. self-observation of thoughts, emotions, behaviours, physiological experiences; performance of behavioural experiments in order to verify own way of thinking; and change in own behaviours in actual situations in real life. During therapy, the therapist remains directive and active, and applies various therapeutic techniques: Socratic questions, downward arrow technique, relaxation training and visual imaging, psychoeducation, and bibliotherapy.

It is noteworthy that Judith Beck [5] formulated 10 major principles of the therapeutic process in cognitive behavioural therapy. Beck emphasized that the therapy should be modified according to individual needs of the patient; however, the principles presented below lie at the bottom of therapy in all patients.

Principle 1. Cognitive therapy is based on evolving, dynamic conceptualization of the patient’s problem. This means that the therapist formulates the problem during the first visit, and subsequently supplements it in the therapeutic process, together with new information obtained from the patient. The therapist presents the conceptualization of the problem to the patient to ensure that it is appropriate.

Principle 2. Cognitive therapy requires a strong therapeutic alliance. The therapeutic relation is warm and empathic. The therapist shows liking towards the patient through empathic remarks, careful listening, thorough summing-up of thoughts and feelings, and realistic optimism and enthusiasm.

Principle 3. Cognitive therapy emphasizes the importance of cooperation and active participation of the patient in this process. During therapy, both the therapist and the patient are active. They commonly establish on what they will work, and what the patient should do within homework assignments.

Principle 4. Cognitive therapy is goal oriented and focuses on the problem. During the first visit the therapist asks the patient to name the problems and goals which the patient desires to attain during therapy. The therapist must adequately understand the problem of a given patient and evaluate the level of the necessary intervention.

Principle 5. Cognitive therapy, in its initial phase, places a special emphasis on the present. The treatment consists mainly in focusing on the current problems of the patient; however, sometimes the therapist reaches into the patient’s past in order to understand

his/her way of thinking at the present moment, or to work out the problem from the past.

Principle 6. Cognitive therapy has an educational character; it teaches the patients how to be one’s own therapist and emphasizes the importance of prevention of recurrences. The therapist educates the patient concerning the nature and course of the disorder, as well as about the process of cognitive therapy and the cognitive model.

Principle 7. Cognitive therapy is to be limited in time. According to Judith Beck, the treatment of patients with uncomplicated depression or anxiety disorders lasts from four to fourteen visits. However, some of them must continue treatment for a year or two, or even longer.

Principle 8. Sessions of cognitive therapy have a specified structure. The therapist asks for a brief report from the previous week, establishes the plan of the meeting, reviews homework, discusses, establishes a new homework assignment, sums up the session and asks the patient for comments. Due to this, the attention is directed to the matters which are most important for the patient, and allows an effective use of time during sessions.

Principle 9. Cognitive therapy teaches the patient to recognize, verbalize and respond to maladaptive thoughts and beliefs. The therapist, through Socratic dialogue, helps the patient to recognize maladaptive thoughts, and asks about the meaning of these thoughts for the patient in order to reveal the basic beliefs about oneself, the world and others.

Principle 10. During a therapeutic session many techniques are applied aimed at changing the patterns of thinking, emotions, and behaviours. The techniques are the techniques of cognitive therapy and the techniques drawn from other approaches (behavioural therapy and Gestalt therapy) [5].

The above-mentioned principles enable the understanding of the essence of cognitive behavioural therapy. It is noteworthy that a cognitive behavioural psycho-therapist acts according to a general plan. This plan contains major theoretical assumptions of this form of therapy, and the features of the therapeutic process: limitation in time, psychoeducation, cooperation of the patient with the therapist.

Thus, the framework of the plan of management in therapy is as follows (after [1]):

Stage 1:

1. Clinical diagnosis. Clinical assessment of the problem, examination of the psychological status of the patient.
2. Conceptualization of the problem.
3. Determination of the goals of the therapy.

Stage 2:

1. Determination of time devoted to attainment of each goal.
2. Planning of techniques of work on attainment of each goal.

3. Interventions oriented towards attainment of goals – reduction of intensity or elimination of the key problems.

4. Evaluation of the effectiveness of the applied techniques of therapeutic work applied.

Stage 3:

1. Prevention of recurrences.

2. Evaluation of the effectiveness of therapy.

3. Completion of therapy.

The above presents the theoretical basis, specificity and essence of cognitive behavioural therapy. This is important for understanding the descriptions of the two processes of psychotherapy of patients.

Case reports

Patient 1

Reported problems, cause of visit

A woman aged 49 hospitalized due to recurrent ulcerative colitis. Recurrent depressive disorder diagnosed by a psychiatrist (F.33). Referred to a psychologist due to low mood, lack of energy and sleep problems.

General information

The patient lives with her father, is employed in the secretariat at a university, and is not in a relationship. She complains of concomitant disorders: ulcerative colitis (since 1998); cataract, osteopenia, cholestasis, recurrent urinary tract infections, inflammatory states of the sinuses, tachycardia, and recurrent infections of the airways. From childhood she has been treated for anxiety-depressive disorders.

Patient's past, traumatic experiences

At the age of 3 years – appendectomy; the patient remembers being fastened to a bed by belts 'I howled for my mother'; aged between 3 and 6 – the patient was sexually harassed by her uncle (she remembered this event when aged 30). When the patient was aged 13 her aunt died, and her parents adopted the aunt's daughter. From that time, she felt 'diminished' and 'less important than her sister'. The patient made 2 suicidal attempts at the age of 16 (by gas) and at the age of 17 (took drugs with alcohol). Due to the suicidal attempts, the patient was psychiatrically treated in a hospital several times. She also received pharmacological treatment with mianserin, fluoxetine, citalopram, sulphiride, trazodone, and amitriptyline. In the course of psychotherapy she also received pharmacological treatment for ulcerative colitis: steroids (periodically), mesalazine, omeprazole, and vitamin D₃. Recent stressful events in the patient's life were her mother's death and grandmother's death. The patient had a difficult relationship with her mother, but they reconciled before the mother's death.

Current problems of the patient

Chronically low mood, apathy, low vital capacity (constant feeling of fatigue), sleep disorders; difficulties with setting boundaries in relations with others – toxic relations; dominant sense of guilt in relationships and the sense of being 'insufficiently good'; the sense of not satisfying her father's ambitions.

In association with the negative emotions dominant in the patient's life, she avoided emotions and difficult situations. This, in turn, caused organizational difficulties in her life, difficulties with planning, postponing until the last moment (avoidance of difficult and unpleasant activities; engagement in substitute activities). In turn, this avoidance caused anxiety and intensification of concomitant diseases, evidenced by weakening of the immune system (recurrent inflammation of the urinary system and airways).

Conceptualization of patient's problems

Automatic thoughts of the patient: 'I am hopeless', 'I will not manage', 'Nothing has any sense', 'I cannot embrace my own affairs'.

Emotions: sadness.

Physiological responses: symptoms of diseases, decreased immunity.

Basic behavioural strategies: difficulties in emotion regulation and avoidance.

Second level of conceptualization: cognitive schemes, typical patterns of responding in the past and their conditioning.

Key beliefs: 'I am hopeless'; 'I do not fulfil parents' expectations'; 'I am insufficient'; 'I let others down'.

Conditional beliefs: 'Even if I try hard, nothing will change'; 'If I feel bad, there is no reason to do anything', 'When I suffer, nobody can help me, so I would be better off dead'.

Typical emotions: sadness.

Basic behavioural strategies: avoidance of emotions and actions.

In the way of thinking: schemes concerning abandonment, black and white thinking.

Patient's goals for therapy

– Learning assertiveness in relations with others (refusal, setting boundaries, talking about own discomfort).

– Work on organization of life (not postponing activities, planning, perseverance).

– Confronting emotions (anxiety, fear, joy).

– Confronting difficult life situations.

– Working out the event of sexual harassment.

Patient's therapy

Twelve therapeutic sessions were planned.

During the initial sessions an interview with the patient was conducted, conceptualization was per-

formed and therapy planned in the context of attaining the patient's goals. During therapeutic sessions the way of the patient's thinking was identified using the technique of Socratic dialogue.

Behavioural techniques of daily action plan and evaluation of performance of this plan were applied. This technique helped the patient to put various things in order and not postpone activities 'for later'. The patient trained for dealing with current matters in real life. Dealing with matters as they arise helped her to regain control over her own life and strengthen self-esteem.

Psychoeducation was used concerning the patient's depression. The depressogenic way of the patient's thinking was triggered at the moment her parents adopted her aunt's daughter. Then the scheme of abandonment by parents was activated in the patient. She felt unimportant and not satisfying the expectations of her parents. The technique of a daily action plan was applied, and the planning of activities pleasant for the patient. The patient started to meet her acquaintances more often.

During therapy the paradoxical technique was used of 'immersing in negative thoughts.' The patient was expected to devote 20 min daily to negative thinking and trying not to think negatively any longer. The goal of this technique is that negative thinking took place within 20 min, and not during the entire patient's day.

The patient was ordered to read books on assertiveness, and patient's beliefs blocking her assertiveness were analyzed. The statements were changed from anti-assertive into pro-assertive. The patient was trained in assertiveness skills.

Traumatic experiences of sexual harassment in childhood were worked out with the patient using exposure techniques consisting in multiple talking about the traumatic experience. The goal was non-avoidance, 'weaving' the traumatic experience into the patient's own system of cognitive representation.

Effects of therapy

The patient attained therapeutic goals. She obtained insight into her own thoughts, emotions, and behaviour. The way of the patient's thinking was modified into a more adaptive way: 'I try to do various things as they arise, then I have control over my life and feel good'; 'Even if I do not have time enough to do something, it is not the end of the world.' The patient also learned to control her own thoughts, express personal opinions, and communicate with others about own discomfort. She worked out the method of solving her problems as they arise, which helped her to take control over own life and strengthen self-esteem. She worked out the trauma of sexual harassment by the exposure technique (recounting traumatic experience many times, the aim being to 'weave'

the traumatic experience into the patient's system of cognitive representation). At the end of therapy the patient's mood was balanced.

Patient 2

Problems reported, cause of visit

A woman aged 32, psychiatrically treated from 2001 due to anxiety states. She reported to a psychiatrist because of sleep disorders. The psychiatrist diagnosed depressive disorder and mixed anxiety disorder (F. 41.2) and referred the patient for psychotherapy.

General information

The patient is employed as an accountant, lives alone, and is in a relationship with a man older than her (she wants to end the relationship). She decided to participate in psychotherapy after cervical shortening surgery (a medium to high degree of dysplasia was diagnosed).

Patient's past, traumatic experiences

In childhood, the patient experienced chronic physical and mental violence from her mother. As a child, she was scared of her mother because she could never predict her reactions. For 12 years she has had no contact with her mother. The father was an alcoholic; he is dead. She has a younger brother. The patient's problems started to build up in 2004, when the La Strada Fund helped the patient to return to Poland from Greece (in Greece the patient ended up in a brothel). In 2003, the patient made a suicidal attempt after parting with her then partner (took drugs with alcohol). Subsequently, at the turn of 2007/8 she self-mutilated (scratched herself and drew blood). She was in several relationships with men – these men were addicted to alcohol or unavailable (married). The relationships lasted for several years. She has several girlfriends. She has undergone 2 psychological psychotherapies (the therapists were male), and a group therapy.

Current problems of the patient

The patient has tendencies towards strong somatic responses of the body (headaches, allergic reactions), only when she gets very nervous. During 'stressful situations' the patient 'winds herself up', becomes increasingly more upset, shouts and intensifies the somatic reactions of the body. In relations with others, there dominates avoidance or control combined with aggression. The patient badly endures unpredictable situations, is inflexible, must have everything planned. She is characterized by perfectionism. When something occurs which is not in accordance with her plans, she gets very nervous. In relations there dominates a sense of guilt and a feeling of being disadvantaged. The patient's problems are also caused by the traumatic expe-

periences from childhood, strongly experienced negative emotions (anger, sadness), and a high level of anxiety.

Conceptualization of patient's problems

Automatic thoughts of the patient: 'I am weak', 'I am of little value', 'I am not worth love', 'Other people want to insult and hurt me.'

Emotions: sadness, anxiety, anger.

Physiological reactions: symptoms of auto-aggression of the body, allergic reactions, sleep problems.

Basic behavioural strategies: difficulties in emotion regulations, avoidance, controlling others, getting nervous, perfectionism.

Second level of conceptualization: cognitive schemes, typical patterns of reacting in the past and their conditioning.

Key beliefs: 'I am not worth love'; 'I am not good enough', 'I am weak'; 'I will not cope if I do not control the situation'; 'Other people want to insult and hurt me.'

Conditional beliefs: 'If I do not control others they will insult and hurt me'; 'If I feel bad it is better to escape than to solve the problem.'

Typical emotions: anxiety, sadness, anger.

Basic behavioural strategies: controlling vs. avoiding other people, emotions and actions, perfectionism.

In the way of thinking: schemes concerning abandonment; black and white thinking.

Patient's goals:

- Learn to control own emotions, 'not to get wound up' in stressful situations.
- Decrease strong physiological reactions of the body, reduce tension.
- Work out traumatic events from childhood.
- Achieve awareness concerning own thoughts, behaviours and emotions.

Patient's therapy

During therapy, an important element for the patient was to establish a safe relation and strong therapeutic alliance with a female therapist. This was especially important for the patient because she had had a distorted emotional bond with her mother. Subsequently, the patient's goals for therapy were established.

The technique of self-observation of thoughts, behaviours and emotions was applied by keeping an observation diary. Using Socratic dialogue, the meanings of individual thoughts and behaviours in the life of the patient were revealed. Through behavioural experiments, the patient learned to control her own emotions in real life (surviving a stressful situation by leaving the home). The patient also learned methods of relaxation, breathing, visual imagery (imagining a safe place). Within the psychoeducation concerning

anxiety and depression, bibliotherapy was applied, and the current responses of the patient and habitual behaviour formed in childhood were discussed. Through exposure techniques, the patient processed a part of the traumatic experiences from childhood, ascribing them meaning in the context of her current life and current problems ('chair work technique'). The patient made her way of thinking in social situations and in relations with others a reality.

Effects of therapy

The patient attained the therapeutic goals. Her somatic symptoms decreased. She learned to control her own emotions in situations when she became upset. Allergic and auto-aggressive reactions were reduced. The patient obtained an insight into her own behaviour, thoughts and emotions. She found a relationship between traumatic childhood and current functioning, and between control and avoidance. She established a strong therapeutic alliance with a female therapist. Through relaxation techniques, the patient learned to control and reduce her level of tension. During therapy she ended the relationship with her previous partner, became involved with a different man and moved in with him. The patient's treatment lasted one year and 9 months. From the time that problems arose at work, the patient decided to participate in daily group therapy; therefore, her individual therapy was suspended. During the last session the problem of avoidance mechanisms was addressed. The therapist posed a hypothesis concerning the participation in a group as a mechanism of avoidance in a difficult situation at work.

Conclusions

The presented article was aimed at presenting the specificity of cognitive behavioural therapy, based on the theory of therapy and examples of therapeutic processes in 2 female patients. It is worth emphasizing that when a patient decides to report for psychological assistance/therapy, he or she should take over the responsibility for his or her own health and life. The essence of psychotherapy is an alteration in behaviour, which can take place when the patient is appropriately motivated (by himself or by the therapist) and changes their way of thinking (dysfunctional thinking about self, the world and others). Introducing the changes into life is difficult and requires work on the part of both the patient and the therapist. At each stage of therapeutic work with a patient, the motivation of the patient, his/her engagement, and the therapist's concern about the quality of the therapeutic relation which enables the process of changes are important [1].

Conflict of interest

The author declares no conflict of interest.

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