Intentional Behavioral Change: A Cognitive-Behavioral Model

Bruce H. Young, LCSW
National Center for PTSD

Nebraska Disaster Behavioral Health Conference
July 14-15, 2005

Overview of Presentation

1. Defining cognitive-behavioral therapy (CBT).
2. Historical roots and rationale of CBT.
3. Which is primary: emotion or cognition?
4. CBT: Current findings
5. New CBT paradigms
6. Intentional Behavioral Change: A CBT model

What is Cognitive-Behavioral Therapy (CBT)?

Defining CBT

No one standard accepted definition… several referents, e.g.,

- Cognitive-behavioral therapy
- Cognitive therapy
- Cognitive mediational therapy
- Cognitive restructuring / reframing

Defining CBT

Form of psychological therapy directly focusing on modifying both cognitive processes and behavior to reduce or eliminate problematic behavior.

What is meant by cognitive process?

A representational state that can be semantically evaluated -- as true or false, accurate or inaccurate -- rules, heuristics, or schemata governing the operation of such representational states, as they are held to be involved in receiving, processing, and storing information.

Historical roots

“Words are the physician
of a mind diseased.”

Aeschylus

Greek philosopher

Contemporary roots

Kelly's constructive alternativism

Method of negotiating and renegotiating meanings by the mediation of narrative interpretation.

Contemporary issues: Cognition and emotion

Which has primacy?...

Does cognition create emotion with the implication … change the cognition and change the emotion?

The limbic system

Group of brain structures including:

- connections with each other
- connections with hypothalamus
- connections with other areas.

.

The limbic system largely associated with emotions.

The neocortex

Neocortex thought to be responsible for higher level cognitive functions – language, memory, complex thought

The neocortex

Consider…

- Affective reactions are possible without cognition
- Affective preferences exist without cognitive awareness
- Affective preferences persevere even if the cognition that gave rise to those preferences is invalidated

How is CBT tied to behaviorism?

Use of conditioning techniques for learning new behavior (e.g., use of systematic desensitization, where a stimulus that causes anxiety is paired with a pleasant one

Positive clinical outcomes tied to empirical change of behavior (as opposed to a type of change viewed by behaviorists as reification of abstract concepts, e.g., self-psychology).

CBT: Empirical studies

Compared symptom course of 10 female victims of rape or aggravated assault who received a 4 session **cognitive-behavioral intervention** shortly after their assault with that of 10 **assessment-only** control victims

Foa, E., Hearst-Ikeda, D., & Perry, K. (1995). Journal of Consulting and Clinical Psychology, 63, 948-955.

Foa, Hearst-Ikeda, & Perry (1995)

Two months after the assault, victims receiving CBT reported experiencing significantly fewer symptoms of PTSD than did assessment control participants.

At a 5.5 month follow-up assessment, participants in the treatment condition reported significantly fewer symptoms of depression, although there were no differences between groups with respect to PTSD symptoms.

Bryant et al. (1998)

- 24 MVA patients with ASD
- Intervention within 2 weeks of trauma

½ received 5 sessions **Supportive Counseling**

½ received 5 sessions **CBT**

Journal of Consulting and Clinical Psychology, 66, 862-866.

Bryant and colleagues (1998)

- **Supportive counseling**
  - Education about trauma reactions
  - Education about general problem-solving skills
  - Unconditionally supportive role
  - Avoided exposure and anxiety management methods
  - Homework: Diaries
    - Current mood states and problems

Bryant and colleagues (1998)

CBT

- Education about trauma reactions
- Progressive muscle relaxation training
- Imaginal exposure to trauma memories
- Cognitive restructuring
- Graded in vivo exposure to avoided situations
- Homework: Daily exposure

Bryant and colleagues (1998)

PTSD at post-treatment:

- Supportive Counseling = 83%
- CBT = 8%

Bryant and colleagues (1998)

PTSD at 6 months:

- Supportive Counseling = 67%

- CBT = 17%

Bryant et al. (1999)

- 45 patients with ASD
- MVA, nonsexual assault
- Randomly assigned to 5.5 hours of 1:1 treatment within two weeks of trauma:
  - **Prolonged exposure**
  - **Prolonged exposure + anxiety management**
  - **Supportive counseling**

American Journal of Psychiatry, 156, 1780-1786.

Bryant and colleagues (1999)

Prolonged exposure (PE)

- Imaginal exposure to traumatic memories
- 4 x 50 minutes (plus rationale session)
- Daily homework of same exercise
- Cognitive restructuring followed exposure in each session
  - Identify irrational, threat-related beliefs
  - Evaluate thoughts against available evidence
- In vivo exposure in last 2 sessions

Bryant and colleagues (1999)

Prolonged exposure + anxiety management (PE+AM)

- Education about trauma reactions
- Breathing retraining
- Progressive muscle relaxation
- Self-talk exercises
- Daily homework in above
- Exposure as above

Bryant and colleagues (1999)

Supportive counseling (SC)

- General problem-solving skills
- Unconditionally supportive therapist
- Diary keeping of current problems and mood states
- No exposure or anxiety management techniques

Bryant and colleagues (1999)

PTSD at post-treatment:

- SC = 56%
- PE + AM = 20%
- PE = 14%

Bryant and colleagues (1999)

PTSD at 6 months:

- SC = 67%
- PE+AM = 23%
- PE = 15%

Bryant and colleagues (1999)

Conclusions:

- ASD can be treated and PTSD can be prevented with brief CBT
- Anxiety management did not add to treatment gains of PE
- Intrusions and arousal declined across all groups

Bryant and colleagues (1999)

Conclusions:

- Dropouts had more severe symptoms
- Cannot generalize to other trauma populations
- Can’t separate out relative effects of exposure and cognitive restructuring

Bryant and colleagues (2003)

Four-year follow-up of 1999 study participants

Conclusion: ASD can be treated and PTSD can be prevented with brief CBT.

Behaviour Research and Therapy, 41, 489-494.

“New” empirically-validated cognitive-mediational paradigms

Emerging and increasing application and modification of eastern philosophies and techniques in western clinical settings

Examples of "New" empirically-validated cognitive-mediational paradigms

"Mindfulness and Acceptance"

Hayes, S.C., Follette, V.M., & Linehan, M.M. (Eds.) (2004). Mindfulness and acceptance: Expanding the Cognitive-Behavioral Tradition. New York: Guilford Press.

"Mindfulness-Based Cognitive Therapy"

Segal, Z., Williams, M,, Teasdale, J. (2002) Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. New York: Guilford Press.

"New" empirically-validated cognitive-mediational paradigms

"Mindfulness-Based Stress Reduction"

Kabat-Zinn, J. (1990). Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness, Delta.

"Choosing to Change"

Young, B.H. (1990). Facilitating cognitive-emotional congruence in anxiety disorders during self-determined cognitive change: An integrated model. Journal of Cognitive Psychotherapy: An International Quarterly, 4, 229-240.

Cognitive-oriented treatments: "New" paradigms

Acceptance and Commitment Therapy (ACT) is based on the theory that much of what we call psychopathology is the result of the human tendency to avoid negatively evaluated private events including certain emotions, cognitions, memories, and bodily states.

The theory is based on a contextual-behavioral analysis of private events and predicts negative effects for direct efforts to control those phenomena.

Hayes, S.C., Strosahl, K., & Wilson, K.G. (1999). Acceptance and Commitment Therapy: An experiential approach to behavior change. New York: Guilford Press.

Cognitive-oriented treatments: "New" paradigms

Mindfulness-Based Cognitive Therapy integrates the evidence-based techniques of Cognitive-Behavioral Therapy (CBT) with elements of Zen meditation practice, relaxation techniques, mindfulness-based stress reduction, and the conscious cultivation of awareness and acceptance.

Intentional Behavioral Change: A Cognitive Behavioral Model

Bruce H. Young, LCSW

Four defining characteristics of "Choosing to Change" CTC

1. Attending to critical role of concentration in intentional cognitive-mediational change

2. Attending to process of facilitating emotional-cognitive congruence

3. Non-pathological model

4. Non-linear model

CTC: Outline of overview

I. Presenting rationale to participants.

II. Brief description of skills & their integration.

III. Description of CTC Monitor

CTC: Outline of overview

IV. Description of “Self-Talk Worksheet.”

V. Environmental and procedural considerations.

I. Presenting rationale to participants

- Explain that program is based on the creative integration of learnable skills individually demonstrated by scientific studies to help bring about positive behavioral change.

Presenting rationale to participants

- Refer to “techniques” as skills to be learned.

- Give rationale for the integration of the learned skills related to self-induced relaxation, focused attention, and conscious self-talk.

Presenting rationale to participants

- Describe and give examples of self-defeating beliefs.
- Describe and give examples of self-defeating emotions.
- Explain the value of social support.

Presenting rationale to participants

- Explain the importance of understanding the “process” of achieving positive behavioral change.

Skills: Attentional muscle relaxation

Basically systematic progressive muscle relaxation procedure with…

added element of attentional focus to simultaneously teach self-induced relaxation and aid development of concrete concentration.

Skills : Attentional breathing relaxation

Attentional breathing (described later)

Used to develop abstract concentration while in a relaxed state.

Skills : Attentional breathing relaxation

Review guidelines for skill development:

1) Each repetition of inhalation and exhalation is done slowly and quietly (“*Another person should not be able to hear your breathing.*”).

2) Each inhalation and exhalation is executed for as long as possible without discomfort while the primary focus of attention is on the sensation of breathing *in* and *out*.

Skills : Attentional breathing relaxation

3) There are four steps; each step is repeated three times. Members are instructed to keep track of step and repetition to help them develop focused attention. A useful method of tracking is to begin with the thumb placed on the lowest of the three sections of the index finger. For each repetition, the thumb is moved one section upward. For each successive step, the corresponding successive finger is used until the thumb has reached the top section of the “pinky.”

Skills : Attentional breathing relaxation

4) Ask members to record level of relaxation/tension on the ***CTC*** monitor.

5) Ask members to sit comfortably and close eyes. Members who wish to keep eyes open are asked to focus attention on a spot in front of them.

Skills : Attentional breathing relaxation

6) Begin the guiding members through four steps:

I. Inhale through nose hold two seconds
Exhale through nose
(Thumb on index finger)

II. Inhale through nose hold two seconds
Exhale through mouth
(Thumb on middle finger)

Skills : Attentional breathing relaxation

III. Inhale through mouth hold two seconds
Exhale through nose
(Thumb on ring finger)

IV. Inhale through mouth hold two seconds
Exhale through mouth
(Thumb on pinky)

Skills : Attentional breathing relaxation

7. Ask members to resume their natural form of breathing and to re-orient to the room. Inquire about members' experience and invite questions. Ask members to record level of relaxation/tension on the ***CTC*** Monitor. Ask if anyone's level of tension increased.

Monitoring skill development

Monitor described and provided to track level of relaxation achieved through the two attentional relaxation procedures.

CTC MONITOR

Use the CTC Monitor to measure your progress with the Attentional Muscle Relaxation (AMR) and the Attentional Breathing Relaxation (ABR). Rate your level of tension / relaxation before and after each practice session using the following scale as a guide:

10 = Absolutely tense	5 = Slightly relaxed
9 = Extremely tense	4 = Moderately relaxed
8 = Very tense	3 = Very relaxed
7 = Moderately tense	2 = Extremely relaxed
6 = Slightly tense	1 = Absolutely relaxed

b = before a = after

After the completing the relaxation procedure, record which skill you used and if you listened to the tape or did the relaxation procedure on your own. Lastly, record if you spoke to your assigned buddy**.**

Example

10	10	10	10	10	10
9	9	9	9	9	9
8	8	8	8	8	8
7 **b**	7	7	7	7	7
6	6	6	6	6	6
5	5	5	5	5	5
4 **a**	4	4	4	4	4
3	3	3	3	3	3
2	2	2	2	2	2
1	1	1	1	1	1

Date:	7-29	_____	_____	_____	_____	____
Skill:	ARM	_____	_____	_____	_____	_____
Tape:	TY	_____	_____	_____	_____	_____
Buddy contact:	BY	_____	_____	_____	_____	_____

Legend

Skill: AMR= Attentional Muscle Relaxation ABR = Attentional Breathing Relaxation

Tape: TY=Yes TN= On my own

Buddy contact: BY= Yes BN= No

ce

CTC: Experiencing relaxed states in less and less time

Attentional muscle relaxation

Sessions 1-3	45 minutes (21 muscle groups)
Sessions 4-8	20 minutes
	(“Collapsing” muscle groups)
Sessions 9-11	10 minutes
Sessions 12-14	5 minutes
Sessions 15-18	1 minute

CTC: Cognitive restructuring "Self-talk" worksheet

Handout in session 2

Worksheet with 10 - step process designed to help begin counter the effects of specific self-defeating beliefs.

Takes several weeks of work to complete.

Self–talk worksheet examples

1. Write down negative thought related to diabetes:

   “I will never be able to control this by changing my diet.”

Self–talk worksheet examples

2. Are you willing to view this thought as negative belief that could potentially cause you further ill health?

“Yes, I can see that thinking that I can’t control the diabetes by following the recommended diet, that I am not giving myself a realistic chance to help myself.”

Self–talk worksheet examples

3. Are you willing to replace this thought with another thought to counter its potential negative effect?

“Yes, I can believe that I am not helpless and there are countless ways in which I can help with treatment.”

Self–talk worksheet examples

4. What might you say to yourself to strengthen this counter-belief? List three thoughts….

“I am not helpless.”

I actually often help myself.”

‘Helping myself is very important.”

Self–talk worksheet examples

5. Summarize these three sentences into one sentence:

“Helping myself is important and means I am not helpless.”

Self–talk worksheet examples

6. Select two to eight words from sentence that represent implied affirmation

“Helping myself important.”

Self–talk worksheet examples

7. Divide this affirmation (phrase) into two or three parts

1. “Helping myself” 2. “Important”

Self–talk worksheet examples

8. After having gained proficiency at either relaxation skill– first go through relaxation protocol; then while in a state of relaxation begin repeating the sections of the phrase (Attentional Cognitive Skill).

1. “Helping myself’ (Slow/long Inhalation)
2. “Important” (Slow/long Exhalation)

Self–talk worksheet examples

9. Describe an actual situation that would be an opportunity to recall your affirmation:

"I am asked by the treatment team to monitor my diet. Instead of believing what's the use, I remind myself that I can help myself and that it is important to do so."

Self–talk worksheet examples

10. Describing and monitoring behavioral change

Case example -- Frequency

If for example baseline is disregarding diet 7 times a week; a reasonable goal for the first three weeks would be to break it 5 times a week; eventually you could reset the goal for two times a week….

CTC: Environmental considerations

Requires group room.

Room should be insulated from loud and distracting noises.

Ideal if the room can have the exact same setup for each session. Uniformity of environmental conditions helps to accelerate learned relaxation response.

CTC: Procedural issues

Check-in process explained so that members can learn how to quickly and effectively use check-in routine.

CTC: Check-in procedure

"We're going to begin each session with a brief Check-in so that you can tell us about your readiness to be in group today. Everybody brings something with them to group, and the Check-in is a time when you can let us know what's on your mind so you can get feedback or help if you need it and so that you can begin to put aside other concerns to concentrate on what's going on here. The process isn't intended to be therapy, but rather a means to help you focus on being here."

Homework

Provide tape recording or CD of skill development procedures to aid home practice.