DOWNLOAD PDF COGNITIVE INTERVENTIONS AND TREATMENTS

Chapter 1 : Behavioral Therapies | National Institute on Drug Abuse (NIDA)

Cognitive Behavioral Therapy techniques come in many varieties to suit your preferences. They can be mixed and matched depending on what works for you. Try the following techniques as self-help.

Tweet patient therapist patients disorders Cognitive therapy is a psychosocial therapy that assumes that faulty cognitive, or thought, patterns cause maladaptive behavior and emotional responses. The treatment focuses on changing thoughts in order to adjust psychological and personality problems. Purpose Psychologist Aaron Beck developed the cognitive therapy concept in the s. The treatment is based on the principle that maladaptive behavior ineffective, self-defeating behavior is triggered by inappropriate or irrational thinking patterns, called automatic thoughts. Instead of reacting to the reality of a situation, an individual automatically reacts to his or her own distorted viewpoint of the situation. Cognitive therapy focuses on changing these thought patterns also known as cognitive distortions , by examining the rationality and validity of the assumptions behind them. This process is termed cognitive restructuring. It can be useful in helping individuals with anger management problems, and has been reported to be effective in treating insomnia. It is also frequently prescribed as an adjunct, or complementary, therapy for patients suffering from back pain , cancer, rheumatoid arthritis, and other chronic pain conditions. Therapy may be in either individual or group sessions, and the course of treatment is short compared to traditional psychotherapy often 12 sessions or less. Therapists are psychologists Ph. Therapists use several different techniques in the course of cognitive therapy to help patients examine thoughts and behaviors. The therapist asks the patient to defend his or her thoughts and beliefs. If the patient cannot produce objective evidence supporting his or her assumptions, the invalidity, or faulty nature, is exposed. The patient is asked to imagine a difficult situation he or she has encountered in the past, and then works with the therapist to practice how to successfully cope with the problem. When the patient is confronted with a similar situation again, the rehearsed behavior will be drawn on to deal with it. The therapist asks the patient a series of questions designed to guide the patient towards the discovery of his or her cognitive distortions. Patients keep a detailed written diary of situations that arise in everyday life, the thoughts and emotions surrounding them, and the behavior that accompany them. The therapist and patient then review the journal together to discover maladaptive thought patterns and how these thoughts impact behavior. In order to encourage self-discovery and reinforce insights made in therapy, the therapist may ask the patient to do homework assignments. These may include note-taking during the session, journaling see above , review of an audiotape of the patient session, or reading books or articles appropriate to the therapy. They may also be more behaviorally focused, applying a newly learned strategy or coping mechanism to a situation, and then recording the results for the next therapy session. Role-playing exercises allow the therapist to act out appropriate reactions to different situations. The patient can then model this behavior. Cognitive-behavioral therapy CBT integrates features of behavioral modification into the traditional cognitive restructuring approach. In cognitive-behavioral therapy, the therapist works with the patient to identify the thoughts that are causing distress, and employs behavioral therapy techniques to alter the resulting behavior. Preparation Cognitive therapy may not be appropriate for all patients. Patients with significant cognitive impairments e. Because cognitive therapy is a collaborative effort between therapist and patient, a comfortable working relationship is critical to successful treatment. Individuals interested in cognitive therapy should schedule a consultation session with their prospective therapist before starting treatment. The consultation session is similar to an interview session, and it allows both patient and therapist to get to know one another. During the consultation, the therapist gathers information to make an initial assessment of the patient and to recommend both direction and goals for treatment. In some managed-care settings, an intake interview is required before a patient can meet with a therapist. The intake interview is typically performed by a psychiatric nurse, counselor, or social worker, either face-to-face or over the phone. It is used to gather a brief background on treatment history and make a preliminary evaluation of the patient before assigning them to a therapist. Typical results Because cognitive therapy is employed for such a broad spectrum of illnesses, and is often used in conjunction with medications and other treatment interventions, it is difficult to measure overall

success rates for the therapy. Cognitive and cognitive behavior treatments have been among those therapies not likely to be evaluated, however, and efficacy is well-documented for some symptoms and problems. Some studies have shown that cognitive therapy can reduce relapse rates in depression and in schizophrenia, particularly in those patients who respond only marginally to antidepressant medication. It has been suggested that this is because cognitive therapy focuses on changing the thoughts and associated behavior underlying these disorders rather than just relieving the distressing symptoms associated with them. The integrative power of cognitive therapy. Harper Collins Publishers, Greenberger, Dennis and Christine Padesky. Content on this website is from high-quality, licensed material originally published in print form. Paste the link into your website, email, or any other HTML document.

Chapter 2 : Cognitive behavioral therapy - Wikipedia

Treatments identified for use include psychotherapy, anxiolytics, antidepressants, psychoeducation, cognitive behavioral therapy, social work and counseling interventions, spiritual counseling and ethics, and palliative care consultation according to algorithms.

These findings are based on data of low quality. There was no clear difference between the groups, and, at present the meaning of this in day-to-day care is unclear. There was no clear difference between the groups. The meaning of this in day-to-day care is unclear. Older individuals in particular have certain characteristics that need to be acknowledged and the therapy altered to account for these differences thanks to age. Because smoking is often easily accessible, and quickly allows the user to feel good, it can take precedence over other coping strategies, and eventually work its way into everyday life during non-stressful events as well. CBT aims to target the function of the behavior, as it can vary between individuals, and works to inject other coping mechanisms in place of smoking. CBT also aims to support individuals suffering from strong cravings, which are a major reported reason for relapse during treatment. The results of random adult participants were tracked over the course of one year. During this program, some participants were provided medication, CBT, 24 hour phone support, or some combination of the three methods. Overall, the study concluded that emphasizing cognitive and behavioral strategies to support smoking cessation can help individuals build tools for long term smoking abstinence. It should be noted that individuals with a history of depressive disorders had a lower rate of success when using CBT alone to combat smoking addiction. CBT therapists also work with individuals to regulate strong emotions and thoughts that lead to dangerous compensatory behaviors. Cognitive behavioral therapy CBT has been suggested as the treatment of choice for Internet addiction, and addiction recovery in general has used CBT as part of treatment planning. Watson The modern roots of CBT can be traced to the development of behavior therapy in the early 20th century, the development of cognitive therapy in the s, and the subsequent merging of the two. Groundbreaking work of behaviorism began with John B. During the s and s, behavioral therapy became widely utilized by researchers in the United States, the United Kingdom, and South Africa, who were inspired by the behaviorist learning theory of Ivan Pavlov , John B. Watson , and Clark L. Skinner and his associates were beginning to have an impact with their work on operant conditioning. Beck was conducting free association sessions in his psychoanalytic practice. The therapeutic approaches of Albert Ellis and Aaron T. Beck gained popularity among behavior therapists, despite the earlier behaviorist rejection of " mentalistic " concepts like thoughts and cognitions. In initial studies, cognitive therapy was often contrasted with behavioral treatments to see which was most effective. During the s and s, cognitive and behavioral techniques were merged into cognitive behavioral therapy. Pivotal to this merging was the successful development of treatments for panic disorder by David M. Clark in the UK and David H. Barlow in the US. This blending of theoretical and technical foundations from both behavior and cognitive therapies constituted the "third wave" of CBT. This initial programme might be followed by some booster sessions, for instance after one month and three months. These are often met through " homework " assignments in which the patient and the therapist work together to craft an assignment to complete before the next session. It is also known as internet-delivered cognitive behavioral therapy or ICBT. CCBT has been found in meta-studies to be cost-effective and often cheaper than usual care, [] [] including for anxiety. CCBT is also predisposed to treating mood disorders amongst non-heterosexual populations, who may avoid face-to-face therapy from fear of stigma. However presently CCBT programs seldom cater to these populations. It has been proposed to use modern technology to create CCBT that simulates face-to-face therapy. This might be achieved in cognitive behavior therapy for a specific disorder using the comprehensive domain knowledge of CBT. This technique was first implemented and developed on soldiers overseas in active duty by David M. Rudd to prevent suicide.

Chapter 3 : Module6-Motivation and Treatment Intervention

"When conducted well, cognitive therapy works as quickly and as thoroughly as antidepressant medications," says DeRubeis, who has led several large studies of cognitive therapy for depression.

At the same time, the practitioners help clients to develop and recognize the discrepancy between their drinking behaviors and their personally held goals and values. This involves highlighting the gap between "where they are" and "where they actually are" deploying discrepancy. As a result, the client will be able to present and "own" the best arguments to support change. In addition, emphasis is placed on avoiding disagreements with clients about the severity of their alcohol problems. Argumentation is counterproductive to the change process and defending positions may breed client defensiveness. No efforts are made to persuade clients about the seriousness of their problems or their helplessness, or in getting them to accept the "alcoholic" label-aspects of many traditional therapies. Resistance is a signal to change or shift strategies. Rolling with resistance means: All efforts to change the drinking behavior are affirmed by the practitioner. The client is the most valuable resource for finding solutions to the problems and is responsible for choosing and executing the change strategies. An important ingredient of the motivational model is client choice. Emphasis is placed on obtaining client agreement about the severity of drinking problems and the kinds of strategies to be used for changing the drinking behavior. To this end, clients are offered a variety of options-including doing nothing. Client commitment can be enhanced by facilitating the belief that there is "a way out" of the problem and by enabling the individual to "do something" about it. No significant differences were found among the three MATCH treatments in total health care costs in the post-treatment period. The cost savings associated with MET may place pressure on health care or managed care providers to adopt such methods in settings where individuals with alcohol problems are typically seen. Many treatment modalities are founded on the assumption that the client is ready to take action, ignoring all other stages of the change cycle precontemplation, contemplation, preparation, and maintenance. It also occurs when more treatment is given than a client wants or when barriers to treatment are ignored. Treatment matching allows for varied responses to be matched to client readiness. For example, in response to precontemplation processes, an intervention can increase awareness and raise doubts about the problematic behavior. In response to contemplation, the interventions are designed to help tip the decisional balance toward action and away from inaction. In preparation, intervention should involve the negotiation of a concrete and workable plan for change. Action interventions, the ones with which we are generally most familiar, assist the client in behavior change through achieving a series of small, progressive steps toward a goal. Maintenance interventions are critical in that they help to prevent relapse and help support ongoing lifestyle change. Subjects in the highest third of the anger variable treated in MET had an average of For angry clients, a non-confrontational approach such as MET may work more effectively to defuse anger or resistance than modalities that are typically more directive. Cognitive Behavioral Therapy Cognitive Behavioral Therapy CBT is based on principles of social learning theory, indicating that the problem behaviors are determined by factors in the social environment. As such, the behaviors can be "unlearned" in the same ways that they were first acquired and are now maintained. CBT focuses on learning alternative coping strategies, rather than alcohol use, to deal with potentially high-risk situations. A functional analysis is conducted to determine target areas for intervention. A wide range of goals are identified and prioritized, and a sequence of interventions is employed to achieve them. Interventions might include assertiveness training, mood management, job seeking skills, anger control, communication training, and planning of leisure-time activities. Opportunities are provided to practice skills inside and outside the sessions i. Typical objectives associated with CBT include social skills training, reduced psychiatric symptoms, anger reduction, social support, and job finding. CBT sessions follow a rule Carroll, The first third of each session is devoted to evaluating and discussing drinking behavior during the past week. Other concerns that might affect drinking behavior, such as marital or family conflict, are also reviewed. The second third of the session is devoted to skills training and rehearsal. For example, a role-play might be used to develop or improve drink refusal skills. The final third deals with planning for the week ahead, including a

discussion of relapse prevention techniques. For example, one client spent the latter part of the session practicing how to deal with criticism on the job without drinking. A role-play was used to teach assertiveness skills to defuse the negative moods that result from such criticism. The latter involved creating alternative lifestyles that would be incompatible with drinking. For example, an individual might choose to regularly attend church services with family members, find stable employment, focus on healthy nutrition, save money, and so on. Those with more alcohol dependence symptoms fared better in TSF. These differences were observed across a number of outcomes pertaining to drinking and health care costs Project MATCH, ; Holder et al. This also has not been confirmed by subsequent research. RET involves a variety of different, but related approaches, all aimed at increasing social support for abstinence, buttressing motivational readiness, improving interactional patterns that promote and reinforce sobriety, and establishing and maintaining emotional ties with members of the social network. Although there are conceptual differences among these approaches systems theory versus social learning theory versus Alcoholics Anonymous philosophy , each involves the promotion and active involvement of a supportive significant other in treatment. The SSO could be a child, parent, friend, clergyman, or member of a self-help group e. Toward this end, methods are used to enhance communication patterns that reinforce social support for sobriety. More specifically, RET can help to: With regard to mutual help i. RET enables the individual to obtain ongoing social support for abstinence. This is an important ingredient of change, especially for those whose natural social networks are not supportive of abstinence. In RET, efforts are devoted to reducing interaction patterns that inadvertently reinforce problem drinking. RET helps non-drinking partners to identify behaviors that trigger or reward problem drinking. It teaches the non-drinking partner or SSO about withdrawing positive reinforcement when the client is using alcohol, and about providing positive reinforcement for nonuse. Examples of the former include not making excuses to an employer for the alcohol use problems i. Examples of the latter include verbally acknowledging nonuse and sharing in activities associated with nonuse, such as attending church services together, exercising, going to movies, gardening, photography, or pursuing other active hobbies. RET Goals and Objectives: It is important to note that effective SSO involved therapy requires that both drinking and relationship issues be addressed during the course of treatment. Interventions that include minimal SSO-involvement i. Long-term results demonstrate the advantages of RET approaches over individual-focused alcohol therapy in terms of increasing length of stay Zweben et al. Both factors are associated with sustaining sobriety. In summary, RET studies show superior results over control groups on a number of outcome measures including drinking, marital stability, motivation, and compliance. Concerning mutual help, it is often unclear whether it is AA attendance or AA participation e. Both were found to be positively related to abstinence Tonigan, et al, in press. These findings offer additional support for mutual help involvement. This may be why some researchers suggest that all clients be routinely encouraged not required to attend mutual help groups, especially those clients who lack a support system for abstinence Westerberg, Limitations of Treatment Outcome Studies Maintaining the Purity of the Treatment Models A major limitation of treatments employed in clinical studies has been the necessity to maintain the purity or integrity of the treatment model. Greater emphasis has been placed on adhering to the integrity of the particular treatment i. Unlike "real world" clinical settings, no attempt is made to integrate components of different models to address client problems. In other words, a person in a CBT skill building program would not have motivation enhancement, while a person in MET would not acquire skills training. The models described here are "pure" models, but the clients are not, and the process in reality is far more eclectic. This means that individuals might have had the ability to improve their coping capacities in CBT, but did not have the requisite motivation to use them. In short, the MATCH treatment outcomes were limited by the need to reduce similarities across the three modalities. At the same time, traditional alcoholism treatment programs have not been responsive to the diverse needs and capacities of the broad spectrum of clients seen in these clinical settings Tucker, The "one size fits all" approach has often been the primary method of treating individuals with alcohol problems. However, the evidence suggests that to best serve individuals with alcohol problems, a repertoire of interventions should be developed, tailored to the differential needs and capacities of a heterogeneous client population, and delivered in a manner that is responsive to the complex problems or issues confronting this group Tucker, A phase model of matching may

be the means by which this is accomplished-see below. The fact that few matching hypotheses were supported, and that some contrasts were in the direction opposite of what was predicted, suggest that current matching theory is under specified. A more adequate theory should specify the circumstances and conditions under which matching effects might appear. Thus, higher order a priori matching hypotheses await testing. Based on the findings emerging from Project MATCH, it is conceivable that individuals with a profile of high self-efficacy, high motivational readiness for change, and high social support for drinking would benefit most from CBT, whereas those with low self-efficacy, low motivational readiness for change and high support for drinking would benefit most from TSF. Use of a Phase Model of Matching Evidence has shown that individuals vary in patterns of alcohol use and related consequences over the course of relapse and recovery Babor, Longabaugh, Zweben, Fuller, Stout, Anton, et al. Some individuals are able to sustain long periods of abstinence, while others may move in and out of sobriety over a lifetime. Some individuals may continue to experience serious negative consequences, despite achieving abstinence, while others may demonstrate major improvements in various areas of life following abstinence. In this model, a broad array of assessment measures is employed. They deal with individual, interactional, and situational factors. These measures are examined in terms of how alcohol use might be directly or indirectly associated with these different areas. For example, is marital conflict a precipitant or consequence of excessive alcohol use? Can we expect an improvement in the marital relationship to be followed by a reduction of alcohol use or vice versa? Decisions about the kinds of strategies to be employed are based on an understanding of how these individual, interactional, and contextual variables interact with the treatment variables to produce good treatment outcomes. For those clients whose environments were highly supportive of drinking, positive change in treatment was predicated on consequent changes occurring outside of treatment-namely, AA involvement. MATCH treatments may have helped to initiate change, but AA participation was necessary to maintain or consolidate its benefits Longabaugh, et al. Thus, in "phase model" terminology, symptom improvement i. In sum, a phase model might offer us some guidance to determine what kinds of strategies might address special problems linked with the drinking, and how best to deliver these strategies to maximize treatment benefits. Nevertheless, phase model matching requires an ongoing, dynamic process of assessment to work.

Chapter 4 : Cognitive therapy - Wikipedia

The main goal of this class are to gain an introductory exposure to the nature of the psychiatric disorder known as schizophrenia as revealed by the scientific method. We will discuss a broad range of findings from the scientific investigation of biological and psychological factors related to.

Treatment can help, and for many anxiety problems, therapy is a good place to start. Certain types of therapy, such as cognitive behavioral therapy CBT and exposure therapy, are particularly beneficial. These therapies can teach you how to control your anxiety levels, stop worrisome thoughts, and conquer your fears. Treating anxiety disorders with therapy When it comes to treating anxiety disorders , research shows that therapy is usually the most effective option. Therapy can help you uncover the underlying causes of your worries and fears; learn how to relax; look at situations in new, less frightening ways; and develop better coping and problem-solving skills. Therapy gives you the tools to overcome anxiety and teaches you how to use them. Anxiety disorders differ considerably, so therapy should be tailored to your specific symptoms and diagnosis. If you have obsessive-compulsive disorder OCD , for example, your treatment will be different from someone who needs help for anxiety attacks. The length of therapy will also depend on the type and severity of your anxiety disorder. However, many anxiety therapies are relatively short-term. According to the American Psychological Association, many people improve significantly within 8 to 10 therapy sessions. How to Choose Many different types of therapy are used to treat anxiety, but the leading approaches are cognitive behavioral therapy CBT and exposure therapy. Each anxiety therapy may be used alone, or combined with other types of therapy. Anxiety therapy may be conducted individually, or it may take place in a group of people with similar anxiety problems. Research has shown it to be effective in the treatment of panic disorder, phobias, social anxiety disorder, and generalized anxiety disorder, among many other conditions. CBT addresses negative patterns and distortions in the way we look at the world and ourselves. As the name suggests, this involves two main components: Cognitive therapy examines how negative thoughts, or cognitions, contribute to anxiety. Behavior therapy examines how you behave and react in situations that trigger anxiety. The basic premise of CBT is that our thoughtsâ€”not external eventsâ€—affect the way we feel. Consider three different ways of thinking about the invitation, and how those thoughts would affect your emotions. A friend invites you to a big party Thought 1: The party sounds like a lot of fun. I love going out and meeting new people! Happy, excited Thought 2: I never know what to say or do at parties. Anxious, sad As you can see, the same event can lead to completely different emotions in different people. It all depends on our individual expectations, attitudes, and beliefs. For people with anxiety disorders, negative ways of thinking fuel the negative emotions of anxiety and fear. The goal of cognitive behavioral therapy for anxiety is to identify and correct these negative thoughts and beliefs. The idea is that if you change the way you think, you can change the way you feel. Thought challenging in CBT for anxiety Thought challengingâ€—also known as cognitive restructuringâ€—is a process in which you challenge the negative thinking patterns that contribute to your anxiety, replacing them with more positive, realistic thoughts. This involves three steps: Identifying your negative thoughts. With anxiety disorders, situations are perceived as more dangerous than they really are. Although you may easily see that this is an irrational fear, identifying your own irrational, scary thoughts can be very difficult. One strategy is to ask yourself what you were thinking when you started feeling anxious. Your therapist will help you with this step. Challenging your negative thoughts. In the second step, your therapist will teach you how to evaluate your anxiety-provoking thoughts. This involves questioning the evidence for your frightening thoughts, analyzing unhelpful beliefs, and testing out the reality of negative predictions. Replacing negative thoughts with realistic thoughts. To understand how thought challenging works in cognitive behavioral therapy, consider the following example: Her therapist has asked her to write down her negative thoughts, identify the errorsâ€—or cognitive distortionsâ€—in her thinking, and come up with a more rational interpretation. The results are below. Challenging Negative Thoughts Negative thought 1: What if I pass out on the subway? Predicting the worst More realistic thought: If I pass out, it will be terrible! Blowing things out of proportion More realistic thought: Jumping to conclusions More realistic thought:

Replacing negative thoughts with more realistic ones is easier said than done. Often, negative thoughts are part of a lifelong pattern of thinking. It takes practice to break the habit. CBT may also include: One of the ways that people do this is by steering clear of the situations that make them anxious. If you have a fear of heights, you might drive three hours out of your way to avoid crossing a tall bridge. Aside from the inconvenience factor, the problem with avoiding your fears is that you never have the chance to overcome them. In fact, avoiding your fears often makes them stronger. Exposure therapy, as the name suggests, exposes you to the situations or objects you fear. The exposure is done in one of two ways: Your therapist may ask you to imagine the scary situation, or you may confront it in real life. Exposure therapy may be used alone, or it may be conducted as part of cognitive behavioral therapy. This step-by-step approach is called systematic desensitization. Systematic desensitization allows you to gradually challenge your fears, build confidence, and master skills for controlling panic. Facing a fear of flying Step 1: Look at photos of planes. Watch a video of a plane in flight. Watch real planes take off. Book a plane ticket. Pack for your flight. Drive to the airport. Check in for your flight. Get on the plane. Systematic desensitization involves three parts: First, your therapist will teach you a relaxation technique, such as progressive muscle relaxation or deep breathing. Creating a step-by-step list. For example, if your final goal is to overcome your fear of flying, you might start by looking at photos of planes and end with taking an actual flight. Each step should be as specific as possible, with a clear, measurable objective. Working through the steps. The goal is to stay in each scary situation until your fears subside. Every time the anxiety gets too intense, you will switch to the relaxation technique you learned. Complementary therapies for anxiety disorders As you explore your anxiety disorder in therapy, you may also want to experiment with complementary therapies designed to bring your overall stress levels down and help you achieve emotional balance. Exercise is a natural stress buster and anxiety reliever. Research shows that as little as 30 minutes of exercise three to five times a week can provide significant anxiety relief. To achieve the maximum benefit, aim for at least an hour of aerobic exercise on most days. Accessing the Relaxation Response Relaxation techniques such as mindfulness meditation and progressive muscle relaxation, when practiced regularly, can reduce anxiety and increase feelings of emotional well-being. Hypnosis is sometimes used in combination with CBT for anxiety. Making anxiety therapy work for you There is no quick fix for anxiety. Overcoming an anxiety disorder takes time and commitment. You can also support your own anxiety therapy by making positive choices. Everything from your activity level to your social life affects anxiety. Set the stage for success by making a conscious decision to promote relaxation, vitality, and a positive mental outlook in your everyday life. Cultivate your connections with other people. Loneliness and isolation set the stage for anxiety. Decrease your vulnerability by reaching out to others. Make it a point to see friends; join a self-help or support group; share your worries and concerns with a trusted loved one. Adopt healthy lifestyle habits. Physical activity relieves tension and anxiety, so make time for regular exercise.