UNIT 6 COGNITIVE AND BEHAVIOURAL APPROACH*

Structure

6.1 Learning Objectives

6.2 Introduction

6.3 Behaviour Therapy

- 6.3.1 Emergence
- 6.3.2 Assumptions
- 6.3.3 Theoretical Frameworks
- 6.3.4 Role of Client and Counselor
- 6.3.5 Techniques
- 6.3.6 Evaluation

6.4 Behaviour Modification

6.5 Cognitive Therapy

- 6.5.1 Emergence
- 6.5.2 Assumptions
- 6.5.3 Theoretical Framework
- 6.5.4 Role of Client and Counselor
- 6.5.5 Techniques
- 6.5.6 Evaluation

6.6 Rational Emotive Behaviour Therapy

- 6.6.1 Emergence
- 6.6.2 Assumptions
- 6.6.3 Theoretical Framework
- 6.6.4 Role of Client and Counselor
- 6.6.5 Techniques
- 6.6.6 Evaluation

6.7 Let us Sum Up

6.8 Key Words

6.9 Answers to Self Assessment Questions

6.10 Unit End Questions

6.11 References

6.12 Suggested Readings

* Dr. Shivantika Sharad, Associate Professor, Department of Applied Psychology, Vivekananda College, University of Delhi, Delhi

6.1 LEARNING OBJECTIVES

After studying this Unit, you would be able to:

- *Develop an understanding of cognitive and behavioural approaches to counseling and therapy;*
- *Explain behavior therapy, cognitive therapy and rational emotive behavior therapy in terms of their assumptions, theoretical frameworks, client-counselor relationship and techniques; and*
- *Analyze the therapies in terms of their applications, advantages and limitations.*

6.2 INTRODUCTION

The field of therapy was largely dominated by the school of psychoanalysis (discussed in unit 4 earlier) in the early 1900s. The second half of the 20th century however, brought about a change in this. In the 1950s a new school of thought arose and this would gain momentum in the next 20 years or so to not only rival the popularity of psychoanalysis, but also be the preferred choice among the two alternatives.

The many behaviour and cognitive approaches that developed during this time differed from psychoanalysis in two key ways:

- They emphasized on *client action* as opposed to client passively waiting for insight
- They believed the *locus of trouble to lie in the present*, as opposed to the past and childhood

In this Unit you will learn about behaviour therapy, behaviour modification, cognitive behaviour therapy, and rational emotive behaviour therapy in terms of their assumptions, theoretical frameworks used, techniques, major applications and limitations.

6.3 BEHAVIOUR THERAPY

6.3.1 Emergence

Behaviourism advanced when J.B. Watson (1913) stated that only observable behaviours can be the empirical roots that will sustain the field of Psychology in the future. The 1950s and 1960s saw psychologists across the globe simultaneously beginning to develop therapeutic approaches that relied on theories of learning. These approaches emerged in the United States, South Africa and Great Britain. They focussed on changing the behaviour of individuals experiencing psychological distress to help them cope better. Phobias, bed-wetting and tension-related disorders were being tackled using insights from Pavlov's classical conditioning. In Africa, Wolpe and Lazarus

(1966) were developing the technique of systematic desensitization around the same time while the theoretical frameworks for operant conditioning were being laid down by Thorndike (1905) and Skinner (1938). Using learning as a basis for therapy soon gained momentum. Bandura's social learning theory (1962, 1977) provided this movement a much needed caveat, i.e. empirically proving the sociological variables that impact learning.

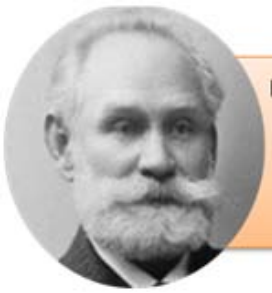
Behavioural repertoire: The sum total of voluntary and involuntary overt behaviours

Learning: A relatively permanent, observable change in behaviour that results from experience and practice

Shaping: Modelling behaviour through demonstration and prompting

6.3.2 Assumptions of Behaviour Therapy

1) Behaviour is a result of the *external environment, internal cognitions and other mental processes* such as attitudes and beliefs.
2) Using *learning theories are a valid method* to bring about significant and lasting psychological change.
3) The *client plays an active role* in decreasing her/his psychological distress by learning new ways of coping and self-management.
4) Effectiveness of therapy is *measurable using empirical methods* i.e. impact of therapy on the client can be measured using standardised psychological tools.
5) Success of therapy is marked by *translation of therapeutic goals to real life situations*, not just reproducing them during sessions or having knowledge and insight regarding them.
6) The therapeutic goals can only be reached if the client has *self-efficacy,* i.e., has faith that change is possible, and that she is capable of bringing about that change.
7) Psychological ailments are not disorders, but *"problems in living"* (Fall, Holden & Marquis, 2017).
8) Therapeutic interventions and *techniques aren't universal and must be tailored* to the needs of each client and their presenting problems.



Ivan Pavlov had a large kennel full of a wide variety of animals. After his initial career wherein he studied short term illnesses and his animals usually died, he devoted his career to studying animals' physiology for a long term. This required him to maintain a large number of healthy animals all at once – hence his kennel

6.3.3 Theoretical Frameworks

The field of behaviourism has moved from its initial conceptualization of a human being as a "tabula rasa" to viewing humans as 'beings' who actively engage with their external environment through an internal world comprising attitudes, beliefs and values. We will be discussing all the main theoretical frameworks in the following section.

Classical Conditioning

Developed by Ivan Pavlov in the 1890s, Classical conditioning pairs a natural stimulus (for instance, a rattlesnake, which naturally elicits fear) with a neutral stimulus (for instance hearing a rattling noise), to get a desired response i.e. *fear*. Eventually this would lead the neutral stimulus to produce the same response as the stimulus i.e. even hearing the rattling noise would elicit fear.

Skinner was extremely investigative as a child. He built telegraph machine that ran from his home to his best friend's home. The two of them even built a machine to separate ripe berries from unripe berries.

Operant Conditioning

This is the model of learning that focuses on rewarding individuals for displaying desirable behaviours and penalising them for displaying undesirable ones. Here learning is achieved through reinforcements and punishments. Reinforcements work to increase desirable behaviour and punishments work to decrease undesirable behaviours.

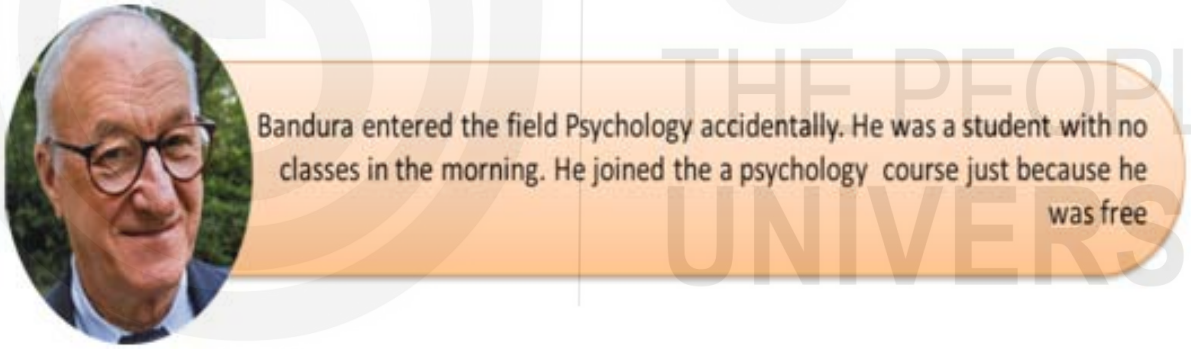
Table 6.1: Positive and Negative Reinforcements and Punishments

	Positive (means adding)	**Negative** (means removing)
Reinforcement (to increase the behaviour)	Adding some pleasurable things to reward the individual (example: giving chocolate to a child for scoring 90% in a test)	Removing something displeasing to reward the individual (example: reduce bad body odour after showering; thus it reinforces taking shower that removesthe negative stimulus of bad smell)
Punishment (to decrease the behaviour)	Adding something displeasing (example: giving child a time-out for throwing a tantrum)	Removing something pleasing (example:not allowing the child to play video games for throwing a tantrum)

As opposed to the prevailing notions at the time, Albert Bandura (1977) highlighted the importance of personal variables and observation in learning. While he agreed that classical and operant conditioning were important modes of learning, he laid emphasis on cognitive mediational processes i.e. the role of thoughts, attitudes and values in learning. He also brought to light the learning that occurs in humans just by virtue of being present in a certain environment, through process like imitation and modelling and termed it *observational learning*. These changes shifted the prevailing paradigm which viewed children as being acted upon by their environment to their being a reciprocal interaction between the environment and individual.

Cognition:The mental processes involved in gaining information, comprehending it and storing it.

Cognitive mediational processes: Values, beliefs and attitudes of each individual towards the stimuli. For instance, if the stimulus of a chocolate covered in a green wrapper is used and the child has had a mint chocolate covered in a green wrapper before and disliked it, the child would not salivate at seeing the chocolate or display behaviours showing a desire for the chocolate.



6.3.4 Role of Client and Counselor/Therapist

Role of therapist in therapy

The therapist's role is that of a teacher and model during therapy. His job entails information collection, designing an intervention and continually subjecting the outcomes of therapy to empirical validation. The process of information collection would require the therapist to ask for presenting problems, clarify them, synthesize an outcome behaviour with the client which would subdue presenting problems, and create a therapy that would lead to that outcome behaviour. The therapist is also responsible for maintaining conditions favourable for behaviour change during the course of the therapy and model ideal behaviour for the client.

Role of client in therapy

The client is an aware participant in the therapeutic process. She aids the therapist in deciding what the outcome behaviour should be and participates in therapeutic work through engagement, cooperation and self-monitoring. These behaviours on the client's behalf are essential for therapeutic work to be successful. The client plays the role of an alert student during the therapy and experiments with a variety of behavioural responses. This eventually allows the client to increase her behavioural repertoire.

Relationship between client and counsellor

While behaviourists understand the appeal for warmth and empathy in a therapy, they do not consider these attributes sufficient for change. Lazarus (1989) considers a client's respect towards the therapist as an essential component of the therapeutic relationship as it allows the client to trust the professional and engage in self-disclosure, both of which are invaluable for therapy to translate into long lasting behavioural outcomes. Behaviourists view counsellors as problem solvers who direct the client towards displaying more adaptive behaviours.

6.3.5 Techniques

The following is a brief description of counselling techniques arising from different behavioural approaches:

1) *Relaxation training:* This method focuses on achieving mental and muscle relaxation. The clients are initially given extensive instructions and then expected to practice it on their own. Relaxation training can last anywhere between 4 to 8 hours of guided instruction (Corey, 2012), but is also being administered in an "abbreviated format" now (McNeil and Lawrence, 2002). Clients are taught the technique and expected to practice it as homework. They may also be required to maintain a log of their practice and experiences related to it.

2) *Role play:* After agreeing upon a behaviour which would be helpful, client and counsellor engage in role play. For example, Kuhu has social anxiety and finds it hard to communicate with strangers in public situation. The counsellor in this case would assume the role of a stranger (boy or girl) and Kuhu (the client) will try to exhibit the *desirable* behaviour. She will go and say "hello" to the stranger and start interaction with her. Role play allows the client to expose herself to the stress-inducing situation in the safe environment of therapy. It also allows her to correct responses she doesn't like, and adapt to the varying styles of conversations that the counsellor chooses. The counsellor can be very kind, or rude or anxious like Kuhu herself!

3) *Graded task assignment:* This is a technique which is used in tandem with other behaviour therapy techniques. An example of graded task assignment during the role-play exercise above would be to first let Kuhu

engage with a mild mannered counsellor-stranger. Step 2 would be to let her engage with someone who is loud and energetic and may be more threatening to approach. Step 3 would be to let her engage with someone who is hostile. The final gradation would be to have her reproduce the results of the role play in the real world. Behaviourism also says that all behaviours can be broken into smaller mini-behaviours. The gradation technique uses this to break a complex task – i.e. talking to strangers – into smaller and increasingly complex behaviours.

4) *Activity scheduling:* This refers to the creation of a daily routine or activity list. The therapist and client together create this in order to provide structure for the client. It helps an anxious client be aware of her priority actions and also answerable to the counsellor for them. It also stops a depressed client from falling back into inactivity and slumber.

5) Pleasure rating: This technique relies on the pleasure received from positive reinforcement. The therapist asks the client to chart how much *pleasure she anticipates before* performing the desired behaviour and the *amount of pleasure she actually feels after* performing the desired behaviour. If the pleasure felt after receiving the reinforcement (for the desired behaviour) is more than anticipated, it provides a push for the client to repeat the *desired behaviour.*

6) *Systematic desensitization:* This technique requires the client and counsellor to chart the client's anxiety provoking stimuli in a hierarchy – from least threatening to most threatening. Let's say that the client is scared of rejection. The client is then exposed to the anxiety provoking stimuli in an ascending order. Once the client begins to master facing the least threatening stimuli (for example, just the thought of being rejected by a stranger), then the therapist moves on to the next level (for example, a person you wanted to befriend ignored you when you said "hi!"). This technique can be employed through imagery – wherein the client and counsellor imagine scenarios and calibrate a response for them or in vivo (real life), wherein the client is asked to perform the behaviours in the real world.

7) *Flooding:* Instead of rating the threatening stimuli in an ascending order, this technique exposes the client to the most threatening stimuli directly and fully after teaching relaxation to the client prior to it– which in the above example could be the client approaching a stranger to befriend, and then stranger not only refusing friendship, but also making fun of the client. This technique uses the theory of classical conditioning. Classical conditioning pairs natural stimulus (need for belonging) with a conditioned stimulus (mockery by peers) to elicit a conditioned response (feeling disheartened, alone and unloved). Flooding relies on the fact that in the absence of the conditioned response (feeling disheartened, alone and unloved), the conditioned stimulus would lose its effectiveness i.e. if we can arrange for a client to feel loved and safe in a therapeutic

environment, mocking by peers wouldn't cause debilitating anxiety after a while.

8) *Aversion therapy:* This technique is employed in order to discourage unhealthy behaviours in clients. This is particularly helpful in cases where clients have drinking, smoking and drug addictions. Here the pleasurable stimulus (alcohol) is paired with a painful stimulus (e.g., mild electric shocks). The client is asked to consume alcohol while the therapist and medical professionals administer mild electric shocks per sips. These shocks act as positive punishment (addition of something unpleasant) and decrease the problematic behaviour.

9) *Eye Movement Desensitization and Reprocessing (EMDR):* This technique has been employed vastly as a solution for trauma. The goal of this technique is to use minimum exposure to trauma and to re-write one's memories to be more adaptive and helpful narratives, instead of anxiety provoking ones. Let's take the case of Riya, a girl who was physically abused by her father as a child and had to be hospitalised as a result more than once. In this case, the therapist recognised through intensive interviews and history taking that Riya's memories cause her to think "I deserved to be hit. I was a bad daughter", which then leads to anxiety attacks. EMDR would require Riya to perform three tasks almost at the same time: 1) recall the memory 2) verbalise what she thinks when she recalls the memory and 3) constantly look at the therapist's index finger which rhythmically moves back and forth at a quick pace. This third task makes sure that though a traumatic memory is being recalled and disturbing cognitions are arising from them, the client is actively engaged in another task physically – looking at the therapist's moving finger. The technique's aim is to rephrase these cognitions into more adaptive statements like, "I was as good as I could be", "I am safe now and there is no need to worry".

6.3.6 Evaluation

Contributions

- **Applications:** Behaviour therapy techniques can be used as interventions for anxiety and phobias (flooding, systematic desensitization, etc.), depression (activity logs, relaxation training, etc.) and even trauma (EMDR).
- **Critical evaluation of both therapy and client:** Neither what the therapist offers nor what the clients think are *"unconditionally accepted"*. The therapist continually evaluates his interventions empirically and also challenges the client's assertions of limitations or *"problems in living"*
- **Ethical benefits of a positivistic inclination:** A behaviour therapist has clear-cut boundaries. They delve in a client's life only to the extent to

impact behaviour – thereby don't have to face many grey areas ethically. Ethicality of the therapeutic relationship therefore can be maintained much more easily.

- **Transfer of knowledge:** Large groups of people can be trained to provide behaviour therapy and as interventions can be learned by all clients, it's effectiveness increases.
- **Time and money effective:** As the therapy is time bound and short term (compared to other modes of therapy), it is monetarily and temporally convenient.
- **Global reach:** As the theoretical roots of this approach are well known, behaviour therapy is available across the globe in in varying formats.

Limitations

- **Power imbalance between the counsellor and client:** This approach views the therapist as the expert and the client as a "student" who must "learn and imbibe" from the therapist. The power dynamics in the therapeutic relationship are therefore lopsided – with the control residing with the therapist. This can result in clients feeling obligated to "go along" with whatever the therapist says, even when they are uncomfortable with it. This can also lead to high attrition rates (clients leaving therapy before completion).
- **Symptom focussed solutions:** Behaviour therapy aims to change behaviour – the symptoms of a supposedly unobservable cause – through theories of learning. The underlying causes however, are never really brought forth. So even though behaviour therapy cause the behaviour to change in specific situations, the cause continues to remain and may continue to cause problems in the future.
- **Lack of emphasis on client's emotional world:** The client's emotional world – how they feel about their problem or the therapy or the therapist – are all not only irrelevant to therapy but not even discussed during the course of therapy. The client's emotional state can be very useful for therapy and provide great insight to a therapist. Ignoring this aspect of a client completely is one big lacking of behaviour therapy.

More to Know:

Clients leaving therapy before completion is very common. In a 2008 article, Barrett et.al. discuss the many reasons why most therapies have a high rate of attrition. The age, gender, ethnicity, distance to travel in order to receive therapy, the waiting period and many more factors come together to determine why clients leave therapy before completion.

1) What do you think happens when people withdraw from therapy before completion?

2) Can you think of reasons why you or someone you know would leave therapy?
3) Should they leave therapy or should they stay?
4) How would you as a counsellor deal with a client who wants to leave?

6.4 BEHAVIOUR MODIFICATION

Using theories of learning in therapy to eliminate or reduce undesirable behaviours is called behavior modification. All the therapeutic interventions mentioned in the section above can be called behaviour modification techniques.

In 1977, an American psychotherapist, Donald Meichenbaum, developed **Cognitive Behavior Modification** (CBM). Much like the behavior modification techniques described in the previous section, this technique also aimed to *change behaviour*.

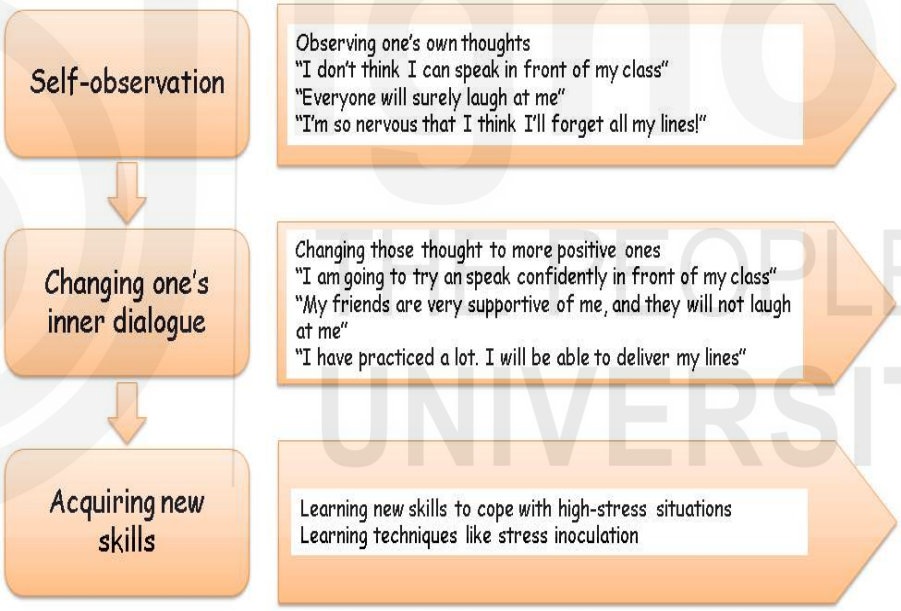


Fig. 6.1: Meichenbaum's Cognitive Behaviour Modification

Unlike the above techniques however, this one focussed on a *person's inner thoughts* as a source of unhealthy behaviour and therefore believed in changing those thoughts in order to change behaviours. Cognitive behaviour modification is a therapy that employs a teaching approach wherein the counsellor teaches the clients (or the client teaches herself) different skills. CBM works in a 3-step framework: (i) observing one's thoughts, (ii) changing thoughts which lead to maladaptive behavior and (iii) acquiring skills that help individuals to cope better. Meichenbaum focussed on helping his clients develop skills to cope with stress, and made the term *"stress inoculation"* famous. Like humans are vaccinated with weaker or dead viruses to help them develop immunity against these viruses, Meichenbaum

thought that exposing people to smaller stressors, bit-by-bit, would help them develop tolerance towards bigger stressors.

Self Assessment Questions 1

1) What is the difference between systematic desensitization and flooding?

……

……

……

2) Name the major theories that provide the bases for behaviour therapy.

……

……

……

3) What is behaviour modification?

……

……

……

BEFORE WE GO AHEAD: Sorting Terminologies

The terms "Cognitive Behaviour Therapy (CBT)" and "Cognitive Therapy (CT)" are often confused. Are they the same? Can we use them interchangeably?

The answer is ***NO.***

Cognitive Therapy (CT) was developed by Aaron Beck and is a type of therapy. CBT on the other hand is an umbrella term used to describe the many kinds of therapies that employ behavioural and cognitive tools to help clients. CBT comprises of at least 20 different therapeutic styles, varying in their techniques but sharing some bedrock assumptions like: the relationship between therapist and client is collaborative, the basis of psychological ailments are cognitive problems, their focus on psycho-education (teaching client to cope better) as a means of changes and rely on the connection between affect, behaviour and cognitions.

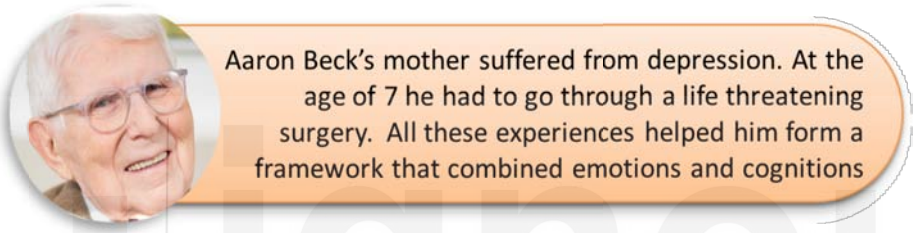
6.5 COGNITIVE THERAPY

6.5.1 Emergence

By the 1960s, behaviour therapy was slowly evolving to include methodologies that worked on the unobservable – on thoughts, emotions and the inner world. The influence of the inner workings of the mind was undeniable. This led to a surge in theoretical perspectives which aimed to

theorize the internal frameworks to study the relationship between cognition, behaviour and emotion.

Beck was on the path to empirically validate Freud's theory when he began his journey as a psychologist. Ultimately, not only he could not verify the Freudian theory, but he began seeing a pattern in his results that led him to create his own theory of psychological ailments. Beck's research repeatedly pointed towards faulty cognitions in patients with depression which eventually led him to describe a depressed client as one with ***"dysfunctional thinking"***. The empahsis here is on how do we interpret or perceive a situation that in turn affects our actions and emotions. So one needs to be aware of these negative interpretations and accordingly change their cognition to engage in alternative ways of thinking and behaving.



6.5.2 Assumptions

1) People's cognitions are made of both ***factual and inaccurate*** thoughts. Both of these kinds of thoughts can co-exist in a person. ***Psychological illnesses*** are a result of the perpetuation of ***maladaptive behaviours*** which result from these inaccurate thoughts. Thus it uses a cognitive model to explain mental health related problems.

2) Humans' minds are capable of ***conscious thinking*** (also called a secondary process), as well as ***unconscious impulses*** (primary process). Cognitive therapy (CT) aims to process all thoughts consciously. CT believes that internal communications can be and should be audited, i.e., brought into conscious focus and examined for validity.

3) The theory also relies on the notion of ***universality in cognition***. Cognition and all the structures that interact with it (emotions, behaviours, etc.) are universal and do not differ from culture to culture.

4) Like behaviourism, cognitive therapy (CT) also relies heavily on ***empirical testing***. Therapists and clients are free to examine the therapy's outcomes objectively and reject the therapeutic structure if it fails to produce results.

5) Unlike behaviourism, however, CT gives the ***client much more authority***. Client has the ultimate authority to describe what a particular cognition (e.g., "I feel stupid") means. The therapeutic framework also strongly relies on the client's motivation and efficacy for change.

6) Therapeutic goal is to change the ***core cognitive schema*** of the client which leads to ***personality change.***

6.5.3 Theoretical Framework

Beck (1976) points out three levels of cognition in the cognitive model which characterize human cognition or the way we think. These are core beliefs or schema, dysfunctional assumptions, and negative automatic thoughts.

Fig. 6.2: Three Levels of Cognition

- **Core Beliefs**

  The human mind consists of thousands of ***schemas*** or concept maps with millions of linkages that help us process information quickly. Since the schemas are mental representations of things/objects/people etc., they can be subject to inaccuracies. For something as factual as the concept of what a dog is, it is easy to correct the schema, but for something as subjective as your worth in the eyes of your parents, the task is much harder. Beck extended this understanding of (objective/factual) schemas to *subjective* thoughts i.e. attitudes, opinions and beliefs. The base schemas which individuals hold on these matters were labeled as their *core beliefs*.

  Thus schemas are deeply ingrained beliefs, our core beliefs which are not easily changeable, are rigid and influenced by early experiences.Beck describes the core beliefs in respect of the 'self' (e.g., "I am not worthy"); 'others or the world' (e.g., 'people are biased'); and 'the future' (e.g., "I will never be happy").

  This ***cognitive triad*** is reflected in the cognitive theory of depression.Beck theorised that depression is a result of three factors, each of which cause and sustain the other two. According to him depression is triggered when a client has (i) a negative view of herself, (ii) tends to interpret most events in her life negatively or through a pessimistic lens and (iii) has a bleak or dark expectation from her future.

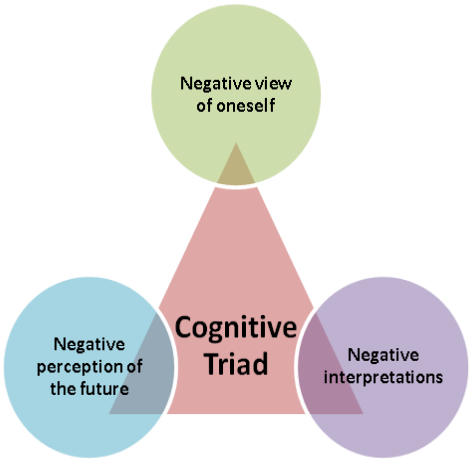


Fig. 6.3: Beck's Conceptualization of Depression: The Cognitive Triad

Furthermore, he explained that people experiencing depression choose to selectively ignore achievements and success that contradict their negative self-concept. All of this leads to the manifestation of a negativity that permeates all parts of the client's life and is labelled as depression.

- **Dysfunctional Assumptions/Beliefs**

  People make various assumptions about how to live their life. Sometimes these assumptions reflect 'conditional rules for living' which are unrealistic. These dysfunctional assumptions or beliefs are maladaptive in nature and lead to problems in interaction and functioning among people.

- **Negative Automatic Thoughts (NATs)**

  Negative automatic thoughts activated spontaneously without any conscious control. These thoughts arise in response to specific situations, for instance, in an interview situation, the person may have negative automatic thought as 'I am going to falter in the interview'.

  Beck noticed how specific ***stimuli triggered an emotional response*** in his patients and that emotional response translated into a *personalised notion* of the patient. These personalized notions which were formulated while in the middle of an emotional response had a high likelihood of being false.

Cognitive Distortions

Beck described many types of "errors in reasoning" that led clients into faulty thinking. These illogical thinking processes or cognitive distortions are unhelpful thinking habits which lead to biases in our thinking. These distortions in our thoughts happen automatically. Hence we need to be aware of them to modify them. Some of the cognitive distortions are described below:

1) *Magnification and Minimization:* The tendency to perceive situations more or less seriously than they are. For instance, failing in one subject

and labelling oneself a "failure" would be magnification; and jumping a red light, crashing into a car and calling it a "tiny mistake" would be minimization.

2) *Labelling and Mislabelling:* The tendency to describe oneself solely on the basis of one's failings. For instance, thinking "I'm a useless, washed up athlete" after losing one race on Sports Day, even though you have won medals in many other races and events.

3) *Personalization:* The tendency to hold yourself responsible for things that rationally can't be caused by you. For instance, believing that your friend's bad mood is definitely because of something you did, even though your friend has denied it and she tends to be upset sometimes because of her family.

4) *Dichotomous thinking:* Thinking in 1s and 0s – things can only be good or bad, never grey. It is also called polarization for its "all or none" approach. For instance, Anushka helped you with your practicum so she's the best! But she did not invite you to her birthday party later that month, so she's the worst and her previous help was fake!

5) *Emotional reasoning:* The tendency to believe that emotional validation is equivalent to rational validation. For instance, thinking that because *you truly feel* that this time your partner meant his apology and he won't abuse you again (even though it has been a repeated behaviour of abuse and apology for a few months now), since you *know it in your heart*, it must be right.

6) *Arbitrary Inferences:* Making judgements in the absence of any real data. For instance, believing that because you didn't take a call from a friend who is dealing with depression, she is going to hurt herself and it will be your fault.

7) *Selective Abstraction:* The tendency to pick isolated details and make inferences from them that are largely out of context. For example, at a party, Ankush's friend remarks, "God Ankush! You're a funny guy to have around! You always make me laugh!" Ankush isolates "funny guy to have around!" and starts thinking that the only reason his friends invite him to events is because he entertains them and his only value is as the joker of the group.

8) *Over generalization:* The tendency to make extreme assumptions on the basis of a single data point; for instance, believing that all teachers think of you as a naughty and disobedient student after being scolded in the class once by the Mathematics teacher.

6.5.4 Therapeutic Technique

Cognitive therapy relies on the client much more than the behaviour therapy. Client's desire to change and the therapist's knowledge about faulty cognitions provide grounds for a collaborative framework. Both collaborators

ensure that they (a)prevent the personality from devolving (b) recognize cognitive anomalies,and **(**c) combat them rationally to bring about the goal of therapy, that is, lasting and positive change in the personality.

Furthermore, it also emphasizes on the client-counsellor relationship. Beck's approach was among the first to focus on the relationship that the counsellor builds with the client. He recognised the counsellor's warmth, empathy, acceptance, rapport building skills as pivotal to the output of therapy.

The techniques used in cognitive behavioural approach can be described under ***cognitive techniques*** (focusing on changing the person's 'cognition') and ***behavioural techniques*** (focusing on changing the person's 'behaviour'). Examples of some cognitive techniques are guided discovery, keeping a positive data log (Padesky, 1994), and thought record, all of which aim at making the individual aware about her thoughts, question their beliefs, analyze evidence for their assumptions, explore alternatives, and look at instances in support of a more positive and adaptive belief/schema.Behavioural techniques include activity scheduling, graded task assignment, behavioural experiments, and relaxation exercises. The focus here is to plan out the day's schedule, engaging in deliberate behaviour and test one's assumptions and beliefs.

Socratic questioning: This is a technique as part of Guided discovery, wherein the therapist asks the client a series of *open-ended*, *thoughtful* and *pin-pointed* questions, which encourage the client to *reflect* on her problems. This requires the client and counsellor to have a well formed rapport and be intensely focussed on the client's issues.

6.5.5 Role of Client and Counselor/ Therapist

Role of the therapist in therapy: The therapist brings knowledge to the therapy - knowledge about how cognitions function, how cognitive distortions arise and how to combat them. The therapist does this by being creative and using Socratic questioning, a method the therapist has honed well. The therapist's knowledge, directive engagement, and questioning together accelerate the process of the client's discovery of her problems. The counselor/therapist's role is to provide guidance to the client and co-investigate issues that she is facing. Collaboration is a feature of cognitive therapy which plays a role while deciding which thoughts are distorted and which are not, what and how much homework would be appropriate for the client, and even while devising novel ways to combat automatic thoughts.

Role of the client in therapy: A client undergoing CT is taught to recognize cognitive distortions. Her job is to (a) realise biased information processing from unbiased one, and (b) to systematically remove these distortions and biases. Over the course of therapy, the client would learn to use conscious control of her thoughts and override the automated distorting and devolving

processes. By the end of therapy, CT aims to make the clients their own therapist.

The counsellor-client relationship: The counsellor client relationship in cognitie therapy is in between of the "student-teacher" approach of a behavior-therapist and the "complete-agency-to-the-client" approach of a humanistic-therapist. The counsellor is an expert in terms of cognitive techniques, functioning of human cognition and techniques that modulate it, but the client is responsible for giving meaning to all her thoughts and contextualizing the therapist's knowledge into her own life. Both determine whether the client's cognitions are reasonable and useful for healthy functioning, thereby preventing present and future dysfunction. The therapy does follow the learning model, but sees the client as an agentic being.

6.5.6 Evaluation

Applications

- **CT's contributions to depression research**: CT largely contributed to the understanding of depression. The prevailing notion about depression labelled it as "anger directed inwards. Beck started viewing depression as a result of cognitive distortion too. To further his approach, he was able to find evidence of distortions in the dreams of his depressed clients. This helped formulate a cognitive theory of depression. Beck is also credited with designing the Beck Depression Inventory and devising and employing CT to specifically aid clients with depression.
- **Other applications:** CT is currently being used for family therapy (where individual and combined family cognitions are scrutinised), anxiety disorders, parent training, skills training and many more areas. The nature of the therapy - brief, client empowering and structured - makes it easy to transfer the basic techniques of CT across different types of settings.

Limitations

1) **Over-simplification of the inner world:** One criticism of CT is that it provides a very simplistic understanding of the inner world of humans. The theoretical assumptions assume that mental processes occur in a very linear fashion: first the individual would have a distorted thought → which will lead to psychological distress → which can be brought to the client's notice → who will remove the distortions. As we are well aware, just knowing about what is logically right doesn't change the way we think about it. This brings us to the second limitation.
2) **Role of emotions overlooked:** Much like behavior therapy, cognitive therapy overlooks the role that emotions play in aiding and prohibiting psychological distress. Though CT allows the client to discuss emotions, it ignores them when it comes to devising an intervention.

Self Assessment Questions 2

1) How do cognitive therapists explain maladaptive behaviour?

   ……

   ……

   ……

2) What is a cognitive triad?

   ……

   ……

   ……

3) Given below are some cognitive distortions. Identify their type.

   a) I could not prepare a healthy meal today. I can never stick to a healthy lifestyle.
   b) I am a failure. I failed in my maths test.
   c) It's because of me that my brother is so rude.
   d) I am feeling anxious. Something bad is about to happen.
   e) A good player should always win.

6.6 RATIONAL EMOTIVE BEHAVIOUR THERAPY

6.6.1 Emergence

Rational Emotive Behaviour Therapy was a type of cognitive behaviour therapy pioneered by Albert Ellis. Ellis came out in strong opposition to the then dominant approach of therapy (psychoanalysis), going so far as to say that not only did the approach fail to help the client feel better, but in most instances, it made them feel worse.

Ellis realised that behavioural methods can also be applied to covert processes and internal dialogues and came up with a therapy that helped clients restructure their philosophical and behavioural styles. Combining his theoretical approach with empirical rigor, Ellis defined an educational approach to provide psychological intervention.

Albert Ellis

"people have remarkable sameness in the ways in which they disturb themselves *emotionally*. They have thousands of specific irrational ideas and philosophies which they creatively invent, dogmatically carry on, and cause great distress and misery to themselves."

6.6.2 Assumptions

1) The source of psychological problems are ***irrational thoughts***. These thoughts are generated by the clients themselves, and therefore, according to REBT, the cause of ***psychological distress are the clients themselves***.

2) Cognitions, emotions and behaviours are ***interrelated and interact*** with each other. Therefore, changes in cognition will eventually bring about behaviour change.

3) Ellis also believed that an individual's ***connectedness*** with other people in her community also determines her psychological well being(Ellis adopted this concept from the Adlerian concept of communality).

4) The process of ***therapy is an educational*** one, wherein the therapist is an expert and the client takes on the role of a student.

6.6.3 Theoretical Framework

- **The Birth of Irrational Beliefs**

  Ellis theorised that our first encounter with irrational beliefs is external. A person of importance or a "significant other" introduces these irrational to an individual during childhood. The individual then *"learns"* these beliefs. Individuals are also capable of creating these beliefs by themselves. Sustaining these beliefs is harmful to the self.Various ways in which these beliefs are sustained involve giving oneself auto-suggestions that these beliefs are beneficial; repetition, e.g., thinking "I am a failure" again and again at the slightest setback; and enacting behaviours supportive of these beliefs, e.g., not participating in competitive activities because you believe that "you're a failure".

- **The Need for Acceptance**

  One of REBT's most radical beliefs is that humans **don't** need acceptance in order to live healthily. It acknowledges that a lack of acceptance from near and dear ones can cause an individual to develop irrational, self-defeating beliefs, but it does not see receiving that acceptance as a cure.

  An REBT therapist would ask a client to face the emotions that come with lacking acceptance - face the sadness, loneliness and even anger. These emotions turn into internal dialogue which is often assigning blame - *"I should be loved by my father. If my father doesn't love me, it*

must mean I am unworthy. But even if I am unworthy, a father should love his child unconditionally".

Two things have happened in this emotion-to-thought change:

i) a blame has been assigned to self, along with the label of being "unworthy". This thought will now have a life of its own, amplifying and validating itself, causing harm to the individual.

ii) The second thing that happened in the emotion-to-thought translation was the creation of rigid and absolutist notions.

Emotions are fluid, we can feel very angry and after the heat of the moment, the anger subsides. But thoughts have a tendency to be much more rigid. Absolutist notions refer to those notions which are uncompromising and don't leave room for any flexibility.

Revisit the above statement and underline the words that show rigidity of thought.

(Answer: *"I should be loved by my father. If my father doesn't love me, it must mean I am unworthy. But even if I am unworthy, a father should love his child unconditionally"*)

Blame and rigidity of thought are what an REBT therapist aims to target and change. The acceptance of another can not be obtained by any therapist, and believing in the agency of an individual (the ability of an individual to act and bring about positive change in her own life), the REBT therapist works on the client instead.

- **The A-B-C Model**

  Imagine you are strolling through the market and you come across a 6 or 7 year old child, who is crying and asking her mother to buy a teddy bear for her. If you are asked the question "why is the child crying", what would you say?

You may say,

a) The child is crying because she wants a teddy bear and she is sad that she can't have one,

b) The child is crying she is throwing a tantrum to get the teddy, or

c) The child is crying because the mother is too strict or unresponsive.

Can you think of other children who are facing a similar situation but are not responding to it by crying? What makes one child respond one way and another respond in another?

The A-B-C model says every situation can have multiple emotional reactions to it, depending upon the way a person chooses to process it.

Fig. 6.4: The ABC Model

Whenever an incident happens **(Activating event)**, our existing thoughts and beliefs related to the event **(Beliefs)** impact the way we respond **(Consequences)** to the incident. Ellis explains that it is our **irrational beliefs** arising from how we interpret the situation/event, that leads to negative consequences. So this modelmakes it possible for applying an intervention (or therapy) to the beliefs (B), in order to bring about change in emotions and behaviours. Hence the focus here is on irrational beliefs of the individual, wheras the focus in Beck's theory is on the cognitive triad.

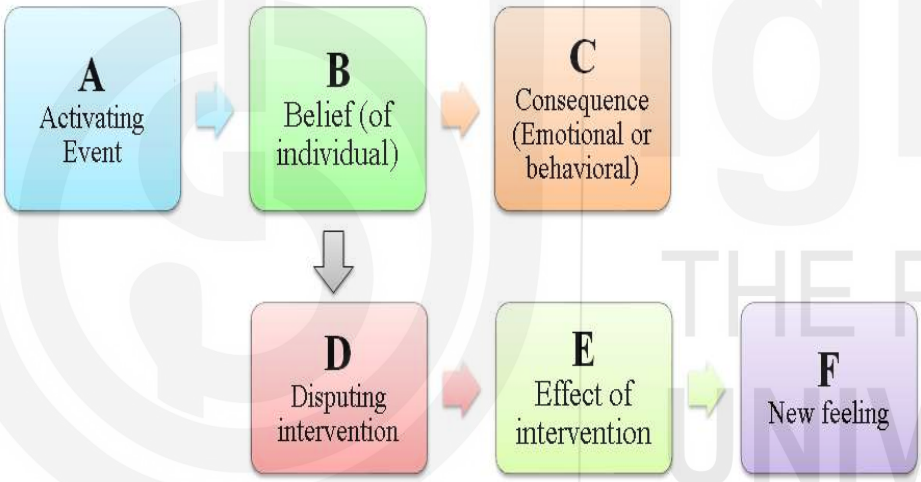


Fig. 6.5: The Mechanism of REBT

The **(D)** here represents the objective questions the clients and counsellors ask about thoughts to verify if they are true or false, **(E)** represents the effects of therapy which eventually causes a change in the way one feels **(F).** Fig. 6.4 above shows how REBT works to change beliefs and bring change in emotions and behaviours.

6.6.4 Techniques

Working on thoughts

1) *Therapist's interruption:* This is part of the process when the client shares her beliefs with the counsellor and the counsellor questions the client objectively and corrects the irrational thoughts.

2) *Self correction:* Clients are also given homework, wherein they are encouraged to identify all their rigid and absolutist thoughts (the ones with "must's" and "should's"). After identifying these thoughts, the clients are encouraged to apply the A-B-C model to change them.

3) *Becoming an REBT teacher:* It is easier to identify the irrationality of another person's beliefs objectively than to identify one's own. This is the reason why clients are encouraged to practice observing irrational beliefs in others as an exercise to become better at identifying them.

Working on behaviours

1) *Language change:* As it has been shown above, simple statements can cause one to develop long-lasting, self-defeating thoughts. Consciously changing one's language to say statements which are less rigid, less absolutist, less self blaming can have a similar long-last but self supportive impact.

Working on emotions

1) *Rational-emotive imagery:* This is an intensive technique where clients are asked to think, feel and act as they want their healed self to. They are also asked to imagine worst-case scenarios, feel however they feel, report those feelings and then try to feel less intensely and more appropriately about such scenarios. It is thought that if clients mentally practice these scenes, when they happen in reality, the clients will be able to respond to them appropriately. (Appropriately here means that even an incident evokes sadness, the client should feel sadness, but not be traumatised)

2) *Using Humour:* According to REBT, emotional disturbance can also result from an individual seeing herself too seriously and losing perspective of the vastness of events in comparison to the whole picture. This is why therapists encourage clients to use humour to tackle the strength and intensity of their thoughts. Counsellors themselves employ humor during therapy to respond to clients.

3) *Shame-attacking:* Ellis devoted much time to developing ways to rid his clients of self-destructive shame. He created exercises and encouraged his clients to stubbornly refuse to feel ashamed. Clients are given assignments where they are asked to act slightly different from social expectations, for instance wearing "loud" clothes, replying in a different waythan the usual to an elder in the family who is rude to you or returning a dish that was wrongly prepared at a restaurant. All these exercises and assignments are aimed at helping the client realise that while the emotion of shame has a role to play, excess of it can be extremely detrimental to the self-image and life of an individual.

6.6.5 Role of Client and Counselor/Therapist

Role of therapist in therapy: The role of an REBT counsellor is complicated. Ellis expected REBT to accept the client unconditionally, but also reject their irrational beliefs openly. This means that the counsellor must come to view the client as a person who makes mistakes, but nevertheless is capable of leading a healthy and successful life. Another aspect of the therapist is that unlike other counselling schools, Ellis did not believe that warmth of a counsellor played a significant role in the success of therapy. He even cited instances where warmth could be harmful. So an REBT counsellor wouldn't spend much time building a warm relationship with the client. REBT requires the counsellor to be good communicators, well-versed in techniques of REBT, competent, active and directive during therapy. They must also be able to diffuse sessions with the timely use of humour.

Role of the client in therapy: The client plays an active and diligent role in therapy. The client is supposed to work hard to continually grow throughout and even after therapy. All clients entering therapy are expected to acknowledge that a problem exists. Additionally a client entering REBT is expected to also accept that irrational beliefs are the core of the problem. Clients are expected to learn and practice REBT techniques, in order to change their beliefs and they are also expected to use these techniques outside the scope of therapy, i.e. if one is going to therapy to deal with marital conflict, the REBT therapist would expect the client to apply those techniques to change irrational beliefs in other domains as well (like problems with friends etc.).

The counsellor-client relationship: As mentioned above, the counsellor-client relationship is that of complete acceptance. Another feature of this relationship is complete honesty from the therapist and an expectation of the same from the client. The counsellor does not hold back objective truths in order to indulge a client's feelings, nor does she encourage long cathartic (when one vents all her emotions by talking) expressions of the client. Ellis saw all these behaviours as obstacles in achieving the true therapeutic goal.

6.6.6 Evaluation

Applications

1) REBT can be applied to marital, family and individual counselling. It has produced outcomes for individuals with anxiety, depression, psychotic disorders, hostility and many more.
2) REBT can also be applied in group sessions, as it employs a teaching mode and requires clients learn some basic techniques to challenge irrational beliefs.
3) REBT is best suited for mild to moderate psychological ailments that require brief intervention.

Limitations

1) *Power imbalance:* The counsellor in REBT is considered an expert. The mode of therapy is itself labelled "teaching". All of this combined gives the therapist a lot of power over the client. Not only can this be misused by the therapist, it can also be a problem if the therapist is not well trained or competent.

2) *Ignoring clients' problems:* REBT places emphasis on a primary problem that needs intervention. The related problems or what are labelled as "secondary problems" are left outside the scope of therapy. This may not be the best approach to bringing about lasting change.

3) *Confrontational style:* REBT encourages therapists to challenge clients' irrational beliefs. This confrontational style may not suit all clients. Moreover, given that this is a brief therapy format that doesn't focus on building a warm relationship, it becomes more difficult to accept a therapist's confrontations.

4) *Balancing the past and the present:* While all forms of behaviour and cognitive therapies focus on the present concerns, completely ignoring the past and early childhood hinders therapy in the long run.

Self Assessment Questions 3

1) Expand the acronym ABCDE as used in Rational Emotive Behaviour Therapy.

   ……

   ……

   ……

2) Give one cognitive, one emotional and one behavior technique as used in REBT.

   ……

   ……

   ……

6.7 LET US SUM UP

In this unit we studied different approaches to counseling from the behavioral and cognitive perspectives. While the behavioral approach looked at the problems of the clients only in terms of maladaptive behaviors, cognitive therapies take into consideration the maladaptive and erroneous thoughts as the basis of client's issues and problems. The unit outlines the theoretical bases of behavioral counseling and cognitive counseling as well as their techniques and therapeutic relationship.

6.8 KEY WORDS

Operant Conditioning refers to the model of learning that focuses on rewarding individuals for displaying desirable behaviours and penalising them for displaying undesirable ones.

Negative Reinforcement refers to removing something displeasing/ unpleasant to reward the individual and increase the likelihood of behaviour.

Positive Punishment refers to adding something displeasing/unpleasant to decreas or reduce the behaviour.

Cognitive Triad consists of negatve view of oneself, negative interpretations about others/the world around, and negative perception of the future.

Cognitive Distortions are illogical thinking processes orunhelpful thinking styles which lead to biases in our thinking.

Dichotomous Thinkingrefers to polarization in thinking, and follows an "all or none" approach, that is, things can only be good or bad.

The ABC Model involves an Activating event orincident; Beliefs, our existing thoughts and beliefs related to the event; and Consequences, the way we respond to the event/incident.

6.9 ANSWERS TO SELF ASSESSMENT QUESTIONS

Self Assessment Questions 1

1) Both systematic desensitization and flooding are behavioral techniques. In systematic desensitization the client is exposed to least threatening anxiety provoking situation/stimulus and is trained to feel secure in it before moving on to more threatening stimulus.While in flooding the client is exposed to anxiety provoking threatening stimulus all at once, in a safe environment and not gradually.
2) Pavlov's Classical Conditioning, Skinner's Operant conditioning and Bandura's Social Learning theories form the bases for behaviour therapy.
3) Behaviour modification is the change in behavioural patterns through the use of learning principles and techniques like reinforcement.

Self Assessment Questions 2

1) Cognitive therapists explain maladaptive behavior primarily on the basis of irrational or erratic thoughts and beliefs.
2) Aron Beck developed the notion of the cognitive triad to describe how depressed adults tend to think about the self, world, and future. They tend to have negative views in all the three domains.

3) (a) Overgeneralization (since on the basis of a single incidence you are making a conclusive judgment about yourself)

   b) Labelling

   c) Self blame

   d) Emotional reasoning

   e) Dichotomous or polarization (all or none thinking)

Self Assessment Questions 3

1) A-activating event, B- belief, C - consequences, D- disputing interventions, E-Effect of intervention, F - New feeling

2) Cognitive technique - Self correction

   Emotional technique - Rational Emotive Imagery

   Behaviour technique - Language Change

6.10 UNIT END QUESTIONS

1) Discuss the assumptions of behaviour therapy.
2) Descrie the techniques of counseling under behavioural approach.
3) Explain the cognitive distortions with examples.
4) Discuss the techniques under Rational Emotive Behaviour Therapy.
5) Discuss the contributions and limitations of cognitive therapy.
6) Explain the role of client and counselor/ therapist in REBT.

6.11 REFERENCES

Alexander, G. M., Wilcox, T., & Woods, R. (2009). Sex differences in infants' visual interest in toys. *Archives of sexual behavior, 38*(3), 427-433.

Bandura, A. (1962). Social learning through imitation. In M. R. Jones (Ed.), *Nebraska Symposium on Motivation*, (p. 211–274). Univer. Nebraska Press.

Bandura, A., & McClelland, D. C. (1977). *Social learning theory* (Vol. 1). Prentice Hall: Englewood cliffs.

Barrett, M. S., Chua, W. J., Crits-Christoph, P., Gibbons, M. B., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training, 45*(2), 247.

Beck, A.T. (1976). *Cognitive therapy and the emotional disorders*. New York: Penguin.

Chapman, A. L. (2006). Dialectical behavior therapy: Current indications and unique elements. *Psychiatry (Edgmont), 3*(9), 62.

Corey, G. (2012). *Theory and practice of counseling and psychotherapy*. Nelson Education.

Dimeff, L., & Linehan, M. M. (2001). Dialectical behavior therapy in a nutshell. *The California Psychologist, 34*(3), 10-13.

Fall, K. A., Holden, J. M., & Marquis, A. (2017). *Theoretical models of counseling and psychotherapy*. Taylor & Francis.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour research and therapy, 44*(1), 1-25.

Lazarus, A. A. (1993). Tailoring the therapeutic relationship, or being an authentic chameleon. *Psychotherapy: Theory, Research, Practice, Training, 30*(3), 404.

Lynch, T. R., Chapman, A. L., Rosenthal, M. Z., Kuo, J. R., & Linehan, M. M. (2006). Mechanisms of change in dialectical behavior therapy: Theoretical and empirical observations. *Journal of clinical psychology, 62*(4), 459-480.

McNeil, D. W., & Lawrence, S. M. (2002). Relaxation training. *Encyclopedia of psychotherapy*, 2.

Meichenbaum, D. (1977). Cognitive behaviour modification. *Cognitive Behaviour Therapy, 6*(4), 185-192.

Padesky, C. (1994). Schema change processes in cognitive therapy. *Clinical Psychology and Psychotherapy, 1*, 267-278. Doi: 10.1002/ cpp.5640010502

Ruiz, F. J. (2012). Acceptance and commitment therapy versus traditional cognitive behavioral therapy: a systematic review and meta-analysis of current empirical evidence. *International Journal of Psychology & Psychological Therapy, 12*, 333-357.

Skinner Burrhus, F. (1938). *The behaviour of organisms*. Appleton-Century-Crofts, Nueva York.

Swales, M. (2012). Dialectical Behaviour Therapy. In W.Dryden (Ed.), *Cognitive Behaviour Therapies* (pp. 93-114). London: Sage Publications.

Thorndike, E. L. (1927). The law of effect. *The American journal of psychology, 39*(1/4), 212-222.

Watson, J. B. (1913). Psychology as the behaviorist views it. *Psychological Review, 20*, 158–177.

Wolpe, J., & Lazarus, A. A. (1966). *Behavior therapy techniques: A guide to the treatment of neuroses*.

6.12 SUGGESTED READINGS

- Capuzzi, D. andGross, D. R. (2007). *CounsellingandPsychotherapy: TheoriesandInterventions*, New Delhi: Pearson.
- Corey, G. (2013).*Theory and Practice of Counseling and Psychotherapy*. Wadsworth
- Sommers-Flanagan, J. & Sommers-Flanagan, R. (2015). C*ounseling and psychotherapy theories in context and practice: skills, strategies and techniques*, 2nd ed. NJ: John Wiley & Sons, Inc.
- Gladding, S.,&Batra, P. (2018).*Counselling: A comprehensive profession*. New Delhi:Pearson.
- Nelson,R. J. (2012).*Theory and Practice of Counseling and Therapy*. New Delhi: SageSouth Asia. (Practicals).
- Sharf, R. S. (2012). *Theories of Psychotherapy and Counseling: Concepts and Cases*.5thEdition. Belmont: Brooks/Cole (Cengage Learning).

Web Resources

- https://www.mayoclinic.org/tests-procedures/cognitive-behavioral-therapy/about/pac-20384610
- https://positivepsychology.com/what-is-cbt-definition-meaning/