UNIT 9 BEHAVIOURAL AND COGNITIVE THERAPIES*

Structure

9.0 OBJECTIVES

After the reading this Unit, you will be able to:

- explain behaviour modification
- discuss cognitive therapy as developed by Aaron Beck;

* Ms. Rachana Singh, Faculty, Department of Psychology, Agra College, Agra (from Unit 1, Block 2 of MPCE023) and Ms. Rashmi Pandey, Faculty, AIHBAS, Amity University, Noida (Unit3 Block 3 of MPC054)

- describe Cognitive Behaviour Therapy (CBT); and
- explain Rational Emotive Behaviour Therapy.

9.1 INTRODUCTION

Let us look at the conversation between Dr. Mahima (Academic Counsellor) and the learners of BAPCH during one of the sessions of BPCC113.

Sonali (Learner): *Maam, we have now learns about psychoanalysis, psychodynamic psychotherapy and also short term therapies. What do we learn about next?*

Dr, Mahima: *Well, next we can discuss about a very important and widely used therapy, that is cognitive therapy. Though we will also discuss about behaviour modification.*

Manpreet (Learner): *Maam the focus of cognitive therapy would be on thoughts right.*

Dr. Mahima: *Thats absolutely right Manpreet. In this session we will learn first about behaviour modification and then we will focus on cognitive therapy and its techniques that can be used to treat various psychological issues and problems. We will also learn about yet another interesting therapy that is rational emotive behaviour therapy.*

Salim(Learner): *Looks that rational emotive behaviour therapy focuses on behaviour, thoughts and emotions as well.*

Dr. Mahima: *Thats right Salim. So let us start with the discussion?*

Learner (all together): *Yes Maam.*

From the above conversation between Dr. Mahima and the learners of BAPCH, you must have got an idea about what we will be discussing in this unit. Though you may have a lot of questions about what these therapies are. So let us look deeply in to these topics.

Holden in 1993 described that thoughts, beliefs, and internal images that individuals have with regard to events in their lives can be termed as cognitions. In this unit we will discuss about two main cognitively-oriented psychotherapies namely cognitive therapy (Beck, 1964) and Rational Emotive Behaviour Therapy (REBT; Ellis, 1962). Cognitive therapies emphasise upon the use of logical faculties to overcome emotional difficulties, as the common premise of all cognitive theories is that thought or cognition determines feeling and behaviour of people. Therefore modification of maladaptive ways of thinking, through various cognitive and behavioural techniques leads to productive change in emotions and behaviour. Though before we proceed to discuss about these cognitive oriented therapies, we will also focus on behaviour modification.

9.2 BEHAVIOUR MODIFICATION*

Learning is an integral part of life. We learn and unlearn many things from our day to day experience. Since we learn things, we can also unlearn those things. The behavioural counselling approach is based on this assumption of learning and unlearning different aspects of behaviour. We tend to acquire and continue those behaviours that are approved, reinforced and rewarded;

*Section 9.2 adapted from Unit 1, Block 2 of MPCE023 and is authored by Ms. Rachana Singh, Faculty, Department of Psychology, Agra College. Agra, UP.

whereas behaviour that is not approved or considered undesirable tend to disappear. Thus the behavioural approach makes use of principles of reward, reinforcement and punishment to bring about desired changes in behaviour. However, this approach was mechanical in nature which assumed that human behaviour is governed by external stimuli only.

Human being is not so mechanical as to be regulated by the S – R (stimulus-response) mechanism. What about the thoughts, perception, feelings and beliefs of the human being? Hence it is not only the mechanical acquisition of physical responses, but the perception of the situation by the child also gets associated with physical responses. This led to the emergence of cognitive behavioural approach (Ellis, 1962; Beck, 1976; Meichenbaum, 1977). According to this approach, thoughts, ideas, beliefs form an important part of behaviour which is learned. The behavioural view ignored the subjective experiences of the individual. The individual was seen as passive human beings having no free will of their own. However, the cognitive behavioural approach considered thoughts, ideas, beliefs as important part of human behaviour.

Behaviour modification is a form of psychotherapy that is based on the learning theories of classical conditioning and operant conditioning. It applies these learning principles to bring about positive changes in behaviour and reduce or eliminate undesirable behaviour. Behaviour modification employs empirically tested behaviour change techniques to improve behaviour and/or reduce maladaptive/undesirable behaviour. It refers mainly to techniques for increasing adaptive behaviour through reinforcement and decreasing maladaptive behaviour through extinction or punishment.

The first use of the term behaviour modification appears to have been used by Thorndike in the year 1911. He talked about the Law of Effect where responses followed by satisfying state of affairs were strengthened whereas responses followed by dissatisfying state of affairs were decreased or discontinued. The learning theories of classical conditioning by Pavlov and operant conditioning by Skinner have further contributed to the development of behaviour modification approach to counselling. Classical conditioning proposes that our behaviour /responses are conditioned, that is, there is an association between the stimulus which elicits the response and our response. When this association becomes strengthened on the basis of reward, conditioning happens and the behaviour is learned. This is the basic conditioning process. Operant conditioning is based on the law of effect. This conditioning consists of behaviour that is followed by consequences that are satisfying to the organism and so will be repeated. Behaviour that is followed by unpleasant consequences will be discouraged. For example, when a child throws temper tantrum, parents give in to his demand. As a result, the child learns that if he throws tantrums, his needs will be satisfied. Here parents attention and giving in to his demand is the reinforcer for the child and thus the child will repeat the same behaviour in the future.

9.2.1 What is Behaviour?

First let us see what do we mean by behaviour? Behaviour is such a term which we use commonly and yet we may not be aware of its exact meaning. We talk about behaviour using the terms such as hard-working,

kind, sociable, ungrateful, independent, selfish etc. However, if we analyse, these terms do not refer to the specific things we note in a person when for instance, we say hard-working or selfish. In general we may understand what selfish behaviour means or nervous behaviour means; but we may not know the person's nervousness refers to his nail- biting, or fidgeting, or pacing in the room? It is very essential that we talk about behaviour very specifically.

Essentially, behaviour is anything that a person says or does. Behaviour modifiers generally talk very precisely about the behaviour. This helps in focusing on the particular aspect of behaviour which need to be changed. Behaviour also need to be described either as behavioural deficits or behavioural excesses. Behavioural deficit refers to something lacking, for example, the child is not able to mix and interact with his classmates; the child has not learned how to eat in a proper manner in a restaurant; the teacher is not able to manage her anger if some child disturbs her class; the manager does not know how to conduct himself in a board meeting. Behavioural excesses refer to behaviour which is out of control, for example, a child showing tantrums; an adult engaged in continuous smoking or drinking; a child eating candies and toffees frequently; or seeing television continuously.

Thus, there is a deviation of behaviour, either lack or excess of behaviour, which causes the problem and need to be addressed. Behaviour modification helps in changing these problem behaviours and establishing the appropriate behaviour. However, one thing to be noted here is that identification of behavioural lack or behavioural excess should always consider the context, the culture and the ethics of the persons involved. Although some behaviour like self injurious behaviour is always inappropriate no matter what the context is.

9.2.2 What is Behaviour Modification?

Behaviour modification can be described as an approach to psychotherapy which is based on learning theory and aims to address the client's problems through techniques designed to reinforce desired and eliminate undesired behaviours. The behaviour modification approach involves the development and encouragement of desirable behaviours and removal and reduction of undesirable behaviours by methods based on the learning and reinforcement principles.

In simple terms, behaviour modification assumes that behaviours can be acquired/ learned and can also be unlearned. Hence if the child has learned any negative behaviour, it can also be unlearned and new desirable behaviour can be learned. Thus the relationship between observable stimuli and response is important; and reward and punishment can be used to control and regulate this relationship between stimulus and response.

Thus, according to Skinner, greater or lesser reinforcement can be used to modify behaviour. For example, Rajan, a 5 year old boy always pushes other children in front of him and has not learned to stand in a line and wait for his turn. Behaviour modification in this case will help the child to change his behaviour by the use of reward and learn to be disciplined while standing in a line.

9.2.3 Principles of Behaviour Modification

Behaviour modification principles and practices are used to assist individuals with developing new, desirable behaviours while eliminating behaviours that are no longer useful. Reinforcement and punishment are the main principles of behaviour modification. Reinforcement strengthens a behaviour, while punishment weakens a behaviour. Both can be either positive or negative.

Positive reinforcement describes desirable behaviour rewarded with a pleasant stimulus, while negative reinforcement describes desirable behaviour rewarded with the removal of a negative stimulus.

Positive punishment occurs when an undesirable behaviour results in the addition of a negative stimulus, while negative punishment occurs when an undesirable behaviour results in the removal of a pleasant stimulus. For example, a rat accustomed to receiving food when pressing the lever, no longer receives food when pressing the lever. The rat has experienced negative punishment. However, positive punishment is not much used, because when misused, more aversive punishment can lead to affective/emotional disorders. The difference between positive and negative reinforcement is that in positive reinforcement, a response/behaviour produces a stimulus (positive reinforcer), whereas in negative reinforcement a response removes the occurrence of a negative stimulus. Examples of positive reinforcers are food, money, recognition; whereas negative reinforcement leads to the learning of avoidance and escape responses. For instance, when we ignore the child when he throws a tantrum, it is a negative reinforcement.

Thus, positive reinforcement as well as negative reinforcement both tend to increase or strengthen behaviour. However, negative punishment , decrease or weaken the undesirable behaviour. When the child misbehaves and given time out (removal of the pleasant stimulus, for example, being with friends), it leads to decrease the undesirable behaviour of the child.

The principles of operant conditioning which are used for the behaviour modification also applies a schedule of reinforcement to bring about the desired results. Target behaviours are reinforced as soon as they occur, while negative behaviours are discouraged. Reward and punishment tools are also used to strengthen new behaviours. In effect, these tools work to redirect a person's motivations toward the desired outcome.

Further, a behaviour, or habit, is framed by what happens before and what happens after the behaviour is carried out. The principle of extinction is also made use of which works by removing or changing what happens after the behaviour takes place. In effect, the incentive or reward that motivates a person to carry out a certain behaviour is taken away. When this happens over and over again, the motivation to indulge in a certain behaviour begins to fade. Eventually the behaviour itself becomes extinct for lack of incentive.

9.2.4 Procedure involved in Behaviour Modification

The goal of behaviour modification is always to bring about a change in the behaviour. The change may be in terms of:

- a newly developed behaviour
- increase or strengthening of a behaviour

- maintaining a behaviour at a particular rate or pattern of occurrence
- decrease or change in a behaviour

Deciding the goal is only one part of the entire procedure for behaviour modification. First of all we need to analyse the problem behaviour through a process of behavioural assessment. Behavioural assessment helps us to understand the problem in its different aspects, in different contexts and across different settings/situations. The problem is studied in detail:

Frequency: How often the behaviour occurs, for example, , how many times the child has used abusive language in a class duration

Duration: How long the problem behaviour lasts, for example, , the child goes on talking abusive language or uses it for a while only

Intensity: How severe is the behaviour, for example, , the child uses extreme abusive language or mild abusive language

Thus baseline data forms an important step in the behaviour modification plan. Specific information about the behaviour is collected. The ABC model of behavioural analysis, also called functional analysis is used. The ABC model refers to

- A is antecedent : It describes what happens just before the occurrence of the behaviour
- B is behaviour: It describes the client's behaviour
- C is consequence: It describes the consequence, that is, what happens after the behaviour

Antecedents help in understanding the problem in detail, what precipitates the problem, when it occurs, at what setting it occurs, who are present, what type of event/ situation usually leads to the behaviour/ problem in question. Behaviour refers to the behaviour shown or demonstrated. Consequences determine the client's behaviour. Consequences refer to what does the behaviour lead to- how do parents, teachers, peer respond to the child's behaviour – this determines whether the behaviour will continue or be modified or decrease or increase.

In other words, the ABC model can be described as follows: What comes directly before the behaviour?", "What does the behaviour look like?", and "What comes directly after the behaviour?" respectively. Once enough observations are made, the data are analysed and patterns are identified. If there are consistent antecedents and/or consequences, an intervention should target those to increase or decrease the target behaviour. If the behaviour pattern shows a particular antecedent or trigger, then intervention can be to avoid that trigger as far as possible and to learn a new behaviour in the presence of the trigger. If a problem behaviour occurs because it achieves some purpose, then there is a requirement to teach an alternative behaviour which will achieve the same purpose without creating any problem.

The functional assessment helps in understanding the behaviour . This facilitates in planning the appropriate intervention technique. The following steps can be delineated in the behavioural assessment process:

The problem behaviour is described in detail with example of its occurrence.

- All the antecedent factors are also elaborated.
- The consequences are noted down.
- The goals are specified.
- Accordingly the target response is stated in precise terms.
- The particular intervention to be used is finalised and implemented.
- Follow up and evaluation is done. If the intervention did not bring in the desired result, then we again go back to the first step of analysing the problem in detail in terms of the antecedent factors and then deciding on the intervention strategies to be adopted.

For instance, the problem is the aggressive behaviour of the child in the playground. Examples of occurrence of the aggressive behaviour by the child in the playground is cited. When did it occur, how did it start, what was the duration and intensity etc. The consequences, how did the teacher react to the aggressive behaviour of the child, how did other classmates present reacted , and any other consequence, may be punishment by the principal of the school are also noted. Analysis of the antecedent and consequences of the problem then leads to the setting of goals. The goal may be to reduce the aggressive behaviour of the child. To achieve this goal, the target response, that is, the response which need to be changed are specified. In this case, the target responses may be reduction in hitting behaviour, using abusive language, overcoming getting angry very quick. Thereafter, the appropriate intervention technique to be used are decided and implemented.

9.2.5 Techniques of Behaviour Modification

Behaviour modification uses different techniques to modify a person's behaviour. It's based on the use of a reward system that targets specific behaviours. Rewards are used to reshape a person's motivations so old habits are eliminated and new, more beneficial habits are formed.

Three techniques of behaviour modification are systematic desensitisation, aversive conditioning and token economy. Other techniques include extinction and biofeedback. The techniques are given in detail in the following paragraphs.

a) Systematic desensitisation

Systematic desensitisation is a behaviour modification practice used to eliminate fears or undesirable emotions. It is based on the classical conditioning principles of pairing anxiety provoking stimulus/event with a relaxation response. Exposure to the fear-producing stimuli while focusing on relaxation techniques eventually leads to the fear-inducing stimuli resulting in the relaxation response, rather than fear. The assumption here is that relaxation and anxiety cannot go together. If we bring in relaxation, then anxiety has to go. Thus, systematic desensitisation uses the principle of counter conditioning, which counters the anxiety connected with a particular behaviour or situation by inducing a relaxed response to it instead. This method is often used in the treatment of people who are afraid of flying. Another example of this practice will be removing the fear of public speaking. This is done by gradually exposing the person to the experience of

public speaking. Speaking in front of the family or a small group of friends may be the first step. The person then gradually works up to speaking in front of a larger group of strangers or associates.

Systematic desensitisation involves the following steps:

Step 1: Constructing an anxiety hierarchy: The first and most important requirement is to construct/prepare a list of all the situation/events/ objects that evoke fear or anxiety in the client. This has to be arranged in a hierarchical order from lowest anxiety provoking stimulus to the highest anxiety provoking stimulus. The degree to which each item produces anxiety is measured in terms of Subjective Unit of Distress (SUD).There should usually be 5-10 SUD difference between each item in the hierarchy. An example of an anxiety hierarchy in case of a person who has fear of speaking in the public is as follows. Rahul is a newly recruited manager of the company and he has to attend a conference of the managers from the region and represent his company's policies and progresses. But Rahul is very anxious about this . Systematic desensitisation can be used to help Rahul overcome his anxiety. First of all the counsellor can help Rahul construct an anxiety hierarchy. The list may be as follows:

- Two weeks before the conference, reading the brochure for the conference of the managers
- Ten days before the conference, discussing with senior managers about things to be presented in the conference.
- Eight days before the conference, discussing with the colleagues about the conference. Six days before the conference, preparing notes on the things to be presented. Four days before the conference, rehearsing the things to be presented
- One day before the conference, keeping the materials ready that need to be taken to the conference.
- The night before the conference day
- Morning of the conference, getting ready for the conference Arriving at the conference venue
- Meeting other managers from other companies
- Rahul's turn comes to present his company's case

Step 2: Training in relaxation: This consists of helping the client achieve a relaxed state of body and mind. Different kinds of relaxation techniques are available. Jacobson's progressive muscular relaxation is commonly used, though it requires training and takes longer time. Among other relaxation methods are 'Shavasana', meditation, 'pranayama' and so on. The main thing here is that the client should find it comfortable and achieve the desired state, that is, relaxation. Jacobson's relaxation technique is based on the premise that muscular tension and relaxation are incompatible. It involves creating muscular tension in each part of the body and then relaxing it. This practice of alternatively tensing and the relaxing the group of muscles one by one creates a very relaxed state, for example, for relaxing hands, make a fist , create the tension , feel it, and the gradually relax them by releasing the hand. When we are in anxious state our muscle groups ate tensed. Hence we need to know how to release that tension and make it relaxed.

Step 3: Presenting anxiety provoking items during relaxation state: The last step is presenting the hierarchy of anxiety provoking items one by one when the client is in a relaxed state. It starts from the lowest anxiety producing stimulus to the highest anxiety producing stimulus. The client relaxes and then presented with the first item in the list, and the the client relaxes again. Then the client is presented the next item in the list. The client visualises each stimulus/situation for at leas 20-30 seconds. If the client experiences anxiety while visualising any particular item, he can stop there and relax; and then visualise a new item in between, for example, in the above instance, if Rahul experiences anxiety at the item – six days before the conference; then a new item can be introduced there – seven days before the conference.

This pairing of anxiety provoking situation with relaxation helps one to be able to face the situation and gradually gain confidence in approaching the real life situation later.

b) Aversive Conditioning

Aversion helps break bad habits through associating aversive stimuli to the undesirable habit. Eventually, the undesirable habit becomes associated with the negative consequence and the behaviour is reduced.. This technique employs the principles of classical conditioning to lessen the appeal of a behaviour that is difficult to change because it is either very habitual or temporarily rewarding. The client is exposed to an unpleasant stimulus while engaged in or thinking about the behaviour in question. Eventually the behaviour itself becomes associated with unpleasant rather than pleasant feelings. One treatment method used with alcoholics is the administration of a nausea- inducing drug together with an alcoholic beverage to produce an aversion to the taste and smell of alcohol by having it become associated with nausea.

c) Token Economy

Human behaviour is routinely motivated and rewarded by positive reinforcement. Token economy is based on systematic positive reinforcement where rules are established that specify particular behaviours that are to be reinforced, and a reward system is set up. A token economy is a highly effective behaviour modification technique, especially with children. In this technique, desired behaviours result in the reward of a token—such as a poker chip or a sticker—and undesirable behaviours result in the removal of a token. When children obtain a certain number of tokens, the children get a meaningful object or privilege in exchange for the tokens. Eventually, the rewarding of tokens decreases and desirable behaviours display independently.

d) Extinction

Eradicating undesirable behaviour by deliberately withholding reinforcement is another popular treatment method called extinction. For example, a child who habitually shouts to attract attention may be ignored unless he or she speaks in a conversational tone. This is based on the principle that if the behaviour is not rewarded or encouraged, it will become extinct.

e) Biofeedback

Behaviour modification principles also can be used to treat emotional problems that are triggered by a physical symptom. Biofeedback is a

method that provides immediate feedback on a person's physiological state, be it heart rate, breathing rate or blood pressure. Feedback is provided by a mechanical device that lets the person know when a particular symptom is present. By controlling the symptom, the resulting emotional response can be prevented. An example of this would be someone who has problems controlling anger. The increases in breathing rate and heart rate can be monitored and controlled with practice. Once controlled, a person is better able to control an angry outburst.

9.2.6 Potentials and Limitations of Behaviour Modification

The whole point of behaviour modification techniques is to change undesirable or harmful behaviours and replace them with healthier, more desirable ones. There are many advantages of the behavioural approach to counselling.

When applied properly, the technique can be effective in working with children, adults and animals also. In fact it can be used for changing the behaviour of any living beings. Animal trainers frequently turn to behaviour modification techniques to help pet owners turn bad habits into good habits. They also make use of behaviour techniques to train animals the different types of new behaviour as we see in animal and birds shows.

Behavioural modification aims at enabling the clients to take charge of their behaviour. Substance abuse counsellors, for example, often encourage clients to take ownership of their behaviours and change them using behaviour modification techniques. The subject/client in the behavioural intervention takes an active role and ownership of the change process.

The basic concepts and methods of behaviour modification are pretty easy to understand and implement.

Behavioural approach focusses on the current behavioural problems in the context of the individual's current environment/situation. It does not analyse the past events/ happenings/situation.

Behavioural intervention spells out achievable behavioural goals in terms that enable you to measure your success. The intervention techniques follow a systemaic step by step procedure. A series of steps are delineated that to bring about change and lead to the desired behaviour.

There are a variety of therapeutic techniques and procedures associated with behaviour modification, so the technique is best used by specially trained, skilled practitioners.

Check Your Progress I

1) What is behaviour modification?

9.3 COGNITIVE THERAPY[1]

Cognitive therapy was developed by Aaron Beck in the early 1960s. He developed psychotherapy for depression that was highly structured, short term and that focused on present. The psychotherapy was developed in order to deal with current problems and to modify dysfunctional behaviour and thinking process (Beck, 1964).

However, since then cognitive therapy has been successfully adapted to a diverse set of clinical problems such as – anxiety and phobias, substance abuse schizophrenia, obsessive compulsive disorder, post-traumatic stress disorder health anxiety, chronic pain, bipolar disorder, chronic fatigue syndrome, eating disorders, and working with couples and families groups, psychiatric inpatients, personality disorders, children and young people and older people.

Intervention in cognitive therapy is based on a cognitive formulation, the beliefs and behavioural strategies that characterise the specific disorder, for example cognitive behaviour therapy for panic disorder involves testing the patient's catastrophic misinterpretations (usually life- or sanity-threatening erroneous predictions) of bodily or mental sensations (Clark, 1989). Anorexia requires a modification of beliefs about personal worth and control (Garner & Bemis, 1985). Substance abuse treatment focuses on negative beliefs about the self and facilitating or permission- granting beliefs about substance use.

9.3.1 The Cognitive Model

The cognitive model, hypothesises that individuals' emotions, behaviours, and physiology are influenced by their perception of events. The situation in itself does not determine the reaction and feeling of the individuals' rather it is associated with how they perceive and interpret the situation which is expressed in "Automatic Thoughts".

1) Automatic thoughts: Automatic thoughts are not the result of deliberation or reasoning. It comes rapidly, automatically and involuntarily to mind and is situation specific. It can be triggered by external events (for example, late for a meeting: 'They'll think badly of me. My opinion won't count. I'll lose their respect') and/or internal events (for example, pounding heart: 'I'm having a heart attack. I'm going to die. Oh God!'). Automatic thoughts are not peculiar to people with psychological distress and it may commonly occur in any individual, for example a student while reading a chapter might have the automatic thought, "I don't understand this," and may feel slightly anxious. However, he may spontaneously (that is, without conscious awareness) respond to the thought in a constructive way: "I do understand some portion of the chapter; let me read the chapter again". This kind of automatic reality testing and responding to negative thoughts is a common experience.

*Section 9.2 adapted from Unit 1, Block 2 of MPCE023 and is authored by Ms. Rachana Singh, Faculty, Department of Psychology, Agra College. Agra, UP.

2) Core beliefs: Core beliefs are the fundamental beliefs that individuals have about themselves, others and the world. The beliefs are formed through early learning experiences in different situations, genetic predisposition toward certain personality traits, and interaction with significant others. The core beliefs are so deeply embedded that individuals do not even articulate them and regard these ideas as absolute truth. Mostly people hold positive and realistic core beliefs (for example, , "I am substantially in control"; "I can do most things competently"; "I am a functional human being"; "I am likable"; "I am worthwhile"). Negative core beliefs mainly activates during emotional disturbance and are characterised to be more rigid, inflexible and concrete than core beliefs of normal individuals. Example of negative core beliefs are - about self, ('I'm weak'), others (other people are untrustworthy") and the world ("The world is a rotten place").

Judith Beck (2005) suggests that negative core beliefs that an individual has about his/her own self can be further classified into three broad categories – helplessness ("I can't do anything right.", "I am out of control."), unlovability (I am undesirable." "I am bound to be abandoned") and worthlessness ("I am unacceptable." I don't deserve to live."). Further, the content of the core beliefs are specific to a particular disorder. For example

- Core beliefs associated with depression viz. helplessness, failure, incompetence, and unlovability.
  - Self: "I am incompetent/unlovable"
  - Others: "People do not care about me"
  - Future: "The future is bleak"
- Core beliefs associated with anxiety viz. risk, dangerousness, and uncontrollability
  - Self: "I am unable to protect myself"
  - Others: "People will humiliate me"
  - Future: "It's a matter of time before I am embarrassed"

3) Cognitive biases/distortions: The information received is processed in a negative or biased manner once the negative core belief is activated. These biases are termed as cognitive distortions that affect the interpretation of events in a way that is consistent with the content of the core belief, thereby maintains the core belief and disconfirm any contradictory evidence. For example, a person experiencing depression after the loss of his/ her job will believe 'I am good for nothing" (fortune-telling) because he/she believes he/she is not good enough (core belief). Let us now look at some of the common information-processing distortions or biases:

a) Selective Abstraction: Under selective abstraction, the focus is on the negative aspect of information rather than the whole information. Example: Because I got low marks in an assignment, I am a failure. Though the person might have scored much better on another assignment. But he/she will focus only on the assignment in which he/ she scored less.

b) Arbitrary Inference: Drawing conclusions in the absence of sufficient evidence. Arbitrary inferences are of two types – mind reading and negative predictions. In, mind reading a person assumes he knows what others are thinking about him, failing to consider other, more likely possibilities. Example: "He thinks that I don't know the first thing about this project". In negative prediction an individual, without any concrete evidence, will believe that something negative is going to take place. Example: "I know I am going to fail in the examination". Such thinking will exist despite of having answered the exams well.

c) Catastrophizing: The future events are negatively predicted without taking in to consideration other more likely outcomes. Example: "I'll be so upset; I won't be able to function at all."

d) Dichotomous Thinking: (also called all-or-nothing thinking): Situations are viewed only into categories instead of on a continuum. In other words one thinks that either something has to be exactly the way he wants or it is a failure. Example: "If I'm not a total success, I'm a failure".

e) Tunnel Vision:Only the negative aspects of a situation are taken in to consideration.. Example: "My superior can't do anything right. He's critical and insensitive and lousy at his work."

f) Overgeneralisation: In overgeneralisation an individual on the basis of a single incidence develop extreme beliefs which they then apply inappropriately to other events. Example: "Because I was uncomfortable at the meeting I don't have what it takes to make friends".

g) Labelling and Mislabelling: In this labels are assigned to oneself and others. These labels are negative and fixed and are not supported with evidence. A person might label and mislabel oneself and others as failure, useless, irresponsible and so on. Example: 'I failed to get the promotion, so I am a failure'.

h) Magnification or minimisation: This type of cognitive distortion occurs when an individual magnify imperfection and minimises good points, and this then leads to a conclusion that supports a belief of inferiority and feeling of depression. Example: "Getting a mediocre evaluation proves how inadequate I am. Getting high marks doesn't mean I'm intelligent."

i) Personalisation: In this an individual relates an external event to themselves even when there is no basis for such a connection. Example: "The person sitting on the next table in the restaurant looked at me harshly because I did something wrong."

9.3.2 Impact of Thought on Reaction Pattern

In a specific situation, individuals' perceptions are influences by underlying beliefs. Further the perception are expressed by situation-specific automatic thoughts. These thoughts, in turn, influence one's emotional, behavioural, and physiological reaction.

Figure 9.1 illustrates how the hierarchy of cognition influence the reaction patterns viz: emotional, behavioural and physiological.

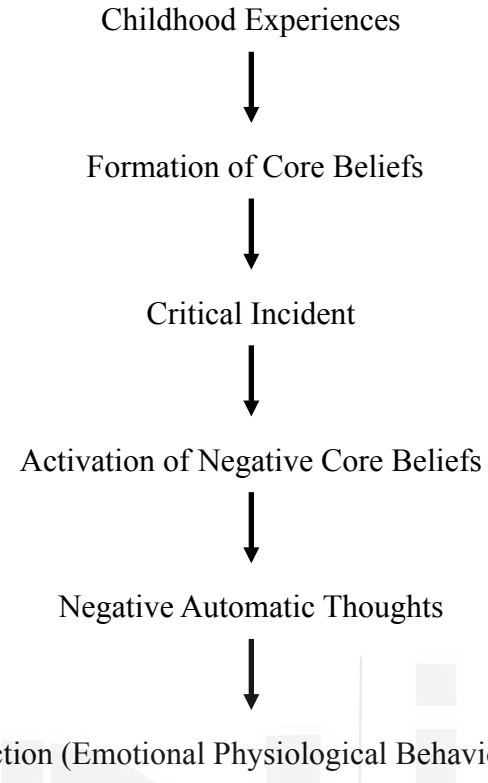
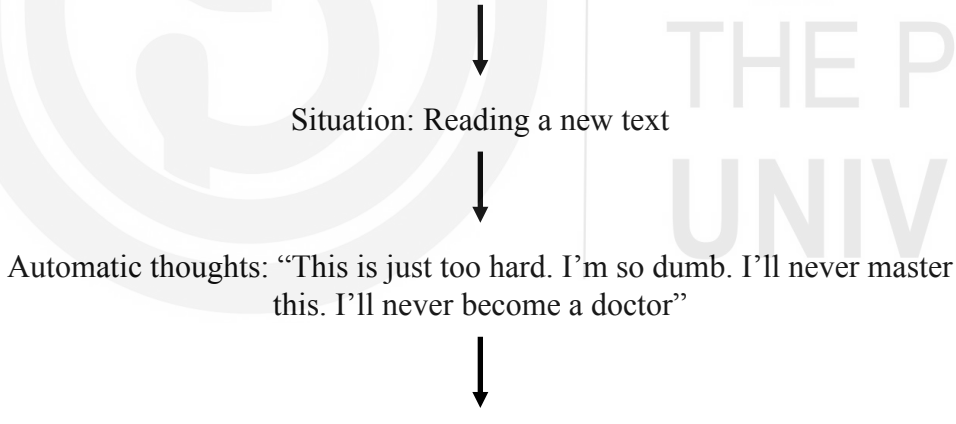


Fig 9.1: The influence of hierarchy of cognition on the reaction patterns

Figure 9.2 illustrates the cognitive conceptualisation of a student illustrating how his beliefs influence his thinking, which in turns influences his reaction.



Physiological: Heaviness in body Behavioural: Avoids task and watches television instead.

9.2 Example of Cognitive Conceptualisation

9.3.3 Therapeutic Relationship

With reference to cognitive therapy, the therapeutic relationship between client and therapist is collaborative in nature. The therapist brings skills and knowledge of psychological processes, to guide the clients in determining goals for therapy and means for reaching these goals. The clients bring their own experiences (thoughts and feelings) for change. The clients participate in the selection of goals and share the responsibility for change and jointly with the therapist explorethe strategies for change.

Thus, the therapist acts as a catalyst with an aim for the clients to attribute improvement in their problems, to their own efforts, in collaboration with the therapist

9.3.4 Therapeutic Process

Cognitive therapy follows a structured approach. In the course of treatment the initial sessions focus on assessment of the problem, development of collaborative relationship, case conceptualisation based on cognitive model and socialisation. As therapy progresses, more emphasis is placed on identifying negative automatic thoughts and beliefs and modifying them. A wide range of cognitive and behavioural techniques are used to identify and to modify dysfunctional thoughts and beliefs. Socialisation is one such technique that involves educating the clients about cognitive therapy, discussing the client's role in the therapy along with the therapist's role and presenting case conceptualisation, wherein the link between cognition, emotion and behaviour is explained. If socialisation is overlooked, clients might be bewildered by the therapist's questions and behaviour and prove more resistant to the clinical interventions than would normally be the case.

1) **Techniques to elicit automatic thoughts:** A basic question is asked to the client to elicit automatic thoughts:

"What were your thoughts at that time"? The therapist asks this question when:

Clients describe a problematic situation or a time

A shift the in (or intensification of) affect is noticed during a session

If clients are unable to answer the question ("What was just going through your mind?") directly, then the question is asked after they respond to the either of the following:

- Ask how they are/were feeling and where in their body they experienced the emotion.
- A detailed description of the problematic situation is elicited
- Client is requested to visualise the distressing situation.
- Client is made to role-play the specific interaction with the therapist (if the distressing situation was interpersonal).
- Client is asked to use imagery to describe the specific situation.

Dysfunctional Thought Records (DTRs): DTRs is used for recording the automatic thoughts that occur during and after or outside the therapy sessions. It will provide the therapist with information about the content of the negative automatic thoughts. Columns are provided in the DTR form in which the client can record details about certain upsetting situations/ events, automatic thoughts, moods as a result of the automatic thoughts. Further the evidence against and for the automatic though can also be recorded. Formulation of balanced thoughts and subsequent changes in the mood can also be recorded. The DTR record can help client identify the triggers that lead to automatic thoughts and create a link between automatic thoughts and moods and emotions. It will thus help in effective evaluation of automatic thoughts so that the client becomes more and more aware by placing them in contexts regularly.

2) **Techniques to modify dysfunctional thoughts/ belief:** A wide variety of cognitive and behavioural strategies are used as a means of cognitive change in cognitive therapy.

9.3.5 Cognitive Techniques

Let us now discuss some of the cognitive techniques

Defining and operationalising terms: The first step in modifying negative automatic thoughts is to understand the meaning, the client attributes to such appraisals, as certain words may have different meaning for different people. For example, a client may state his main fear is of 'losing control'. The fear could be of losing behavioural control, losing mental control and its appraised consequences. Some useful questions for operationalising terms are:

- When you say that you will (lose control, cannot cope) what do you mean?
- If you could not (control, cope etc.) what is the worst that could happen?
- What would (cannot cope, lose control etc.) look like?

Guided discovery and Socratic questioning: Guided discovery is a process whereby the therapist acts as a guide to help clients uncover and examine their maladaptive thoughts and beliefs by asking them a series of questions to help them gain distance (that is, , see their cognitions as ideas, not necessarily as truths), evaluate the validity and utility of their cognitions, and/or decastastrophize their fears and discover new ways of thinking and behaving The series of questions are termed as Socratic questions (the Socratic questioning method, derived from the philosopher Socrates, involves a dialectical discussion.)

Beck et al. (1993) states that Socratic questions 'should be phrased in such a way that they stimulate thought and increase awareness, rather than requiring a correct answer'. Let us now look at the examples of Socratic questioning,

1) What evidence supports this idea? and what evidence is against this idea?
2) Is there an alternative explanation or viewpoint?
3) What is the worst that could have happened? If it happened, how could would cope? What is the best that could have happened? What is the most realistic outcome?
4) What are the consequences of your believing the automatic thought? What could be the consequences of changing your thinking?
5) What would you tell [a specific friend or family member] if he or she were in the same situation?
6) What actions should you take?

Reattribution: Clients often take up responsibility for events and situations for which they are not solely responsible and this makes them feel guilty and depressed. Therapists help clients to distribute the responsibility of the event fairly. Different types of reattribution procedures are psychoeducation,

Socratic questioning, and homework assignments. For example a student felt that she got "C" in her exams because she is incompetent. Through Socratic questioning therapist helps her to evaluate her dysfunctional thoughts and find other reasons for her failure.

Therapist: how much do you believe that you got a C on your exam because you're basically incompetent?

Client: Oh, close to 100%.

Therapist: I wonder if there might be any other reasons.

Client: . . . Well, there were some portions that were not really covered in class.

Therapist: Okay, anything else?

Client: I missed two classes, so I had to borrow notes, and my friend's notes were not that good.

Therapist: Anything else?

Client: I don't know. I studied some things a lot that did not come in the exam.

Labelling distortions: Identifying and labelling cognitive distortions help in invalidating the negative automatic thoughts and beliefs. In this initially the client is asked list their automatic thoughts and then he/ she is asked to rate his/her beliefs for the listed automatic thoughts on a scale of 0-100. Next, the distortions in each thought are identified. Thereafter a rational response is substituted for each thought that is followed by a rating of belief in each alternative response. It relies on teaching clients to identify thinking errors in their automatic thoughts.

Decatastrophising: This technique is used to help client's evaluate that they are overestimating the nature of a situation, and overcome their fear of an outcome that is unlikely to happen. Decatastrophising procedure involves examining negative automatic thoughts for their validity, looking for previously unrecognised attributes, interests, or coping mechanisms and stimulating the client to look beyond the immediate situation. "What if" technique is used by the therapist wherein the therapist asks the client, if X happens what would be the worst that could happen in this situation?, and the client has to give answers to explore actual rather than feared events

Cognitive continuum: This technique is useful to modify both automatic thoughts and beliefs that reflect polarised thinking, (that is, , when the patient sees something in all-or-nothing terms) such as a student believing if she is not a superior student, she is a failure. She might be asked to draw a horizontal line representing the full continuum of her belief from 0% to 100%. Then she will be asked to indicate a rating at which she falls on the continuum (for example, 0%). The student then is asked to provide ratings for other students as well on that continuum. (for example, students who would be considered at 20%, 30%, criteria, through 80% and 90%). Simultaneously, the student repeatedly revises where she stands on the basis of these anchors.

In most instances, when clients consider the full spectrum of people who could be included on this continuum, they generally conclude that they are comparably in a favourable position.

Advantages and disadvantages analysis: This technique serves two aims; a) increases patients' motivation; b) helps in eliciting assumptions or beliefs underlying the maintenance of particular cognition. In advantages-disadvantages analysis, the client is asked to draw a 4 × 4 quadrant, with the old belief and the new core belief listed across the top, and "advantages" and "disadvantages" listed down the side. Then, clients record the advantages and disadvantages of each belief. An effort should be made to generate more disadvantages of the old negative belief as it would motivate the client to change by becoming aware of the reasons chosen by them to change their thought and behaviour.

Intellectual–emotional role play: Also known as called point–counterpoint, this technique is useful when clients say that emotionally they feel the belief is true but intellectually they can see that a belief is dysfunctional. In such a situation therapist first asks the client to play the "emotional" part of their mind that strongly endorses the dysfunctional belief, while therapist plays the "intellectual" part. In the second segment roles reverse. In both the segments, both therapist and client speak in the first person "I." This kind of switching in the roles provides the clients with an opportunity to speak with the intellectual voice that modelled by the therapist. Therapists use the same emotional reasoning and the same words that the patients used. Using their (clients) own words and not introducing new material helps clients to respond more precisely to their specific concerns. If clients are unable to formulate a response while in the intellectual role, therapists either switch roles temporarily or come out of role to discuss the stuck point.

Check Your Progress II

1) List any two cognitives techniques.

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9.4 COGNITIVE BEHAVIOUR THERAPY (CBT)

The Cognitive Behaviour Therapy is based on Cognitive model. In fact, the term "Cognitive therapy" is now used synonymously with "cognitive behaviour therapy"

However, in cognitive therapy where the stress is on the cognitive aspect, in cognitive behaviour therapy, both cognitive and behaviour are focused on.

Earlier in this unit we developed a fair idea about the cognitive therapy. Let us now discuss the principles of cognitive behaviour therapy.

9.4.1 Principles of Cognitive Behavioural Therapy

The following are the principles of cognitive behavioural therapy:

1) **Cognitive behaviour therapy requires a sound therapeutic alliance:** Therapeutic relationship needs to involve empathy, warmth, and a little bit of appropriate humour and creativity to stimulate the

therapeutic dialogue. This helps in order to enhance the process of identifying and modifying beliefs that are maladaptive.

2) **Cognitive behaviour therapy emphasises collaboration and active participation of the client:** The therapy is seen as teamwork and the client is encouraged to actively participate during sessions. Further decision regarding how often the client and therapists should meet, and what homework will the client carry out is decided by both the client and the therapist together.

3) **Cognitive behaviour therapy is goal oriented and problem focused:** CBT targets on the discrete problems rather than vague and amorphous goals of feeling good, getting better or increasing self-esteem. The therapist works with the client on generating solutions and not simply gaining insight into the problems.

4) **Cognitive behaviour therapy is educative:** In the initial session the therapist educates the client about the nature and course of the disorder, about the process of cognitive behaviour therapy, and about the cognitive model (that is, how thoughts influence emotions and behaviour). The therapist also plays an active role in helping the client in setting goals, identifying and evaluating thoughts and planning behavioural change during the therapeutic process.

5) **One of the aims of cognitive behaviour therapy is to be time limited:** Based on the symptoms displayed by the client the sessions are determined. Certain clients will require comparatively lesser time than others. Clients with depression and anxiety disorders may be treated for around six to 14 sessions. Whereas certain other clients may require 1 or 2 years of therapy or even longer in order to modify their rigid dysfunctional beliefs and patterns of behaviour.

6) **Cognitive behaviour therapy sessions are structured:** The sessions in CBT are structured. The therapy will follow a structure that is similar to a treatment plan. First, the overall therapy follows a structure that approximates the treatment plan. Each session is planned and structured in such a way that it will have a beginning that will include mood checking, review of the week, setting goals/ agenda together for the session. It will also include a middle part that has to do with review of the homework, discussions about the goals/agenda and problems faced in achieving the goals/ agenda, setting new homework and summarisation of the session. The final part includes seeking feedback of the client. This format helps the client to understand the therapeutic process in much better manner and enhances the chances of self therapy after termination.

7) **Cognitive behaviour therapy emphasises on the here and now problems:** The focus of CBT is on present and current problems of the client. However, the problems or issues in the past are considered only when the need is strongly expressed by the client and failure to comply could negatively affect the therapeutic relationship. Past issues are also considered when the client is not able to get rid of the dysfunctional thinking and therefore the roots of their beliefs during childhood need to be explored in order to help the client adequately.

9.4.2 Goals of of Cognitive Behavioural Therapy

The main goals of CBT are to help clients identify, inspect, challenge and argue the beliefs and thinking in present that is affecting them in a negative manner. Further the goal of this therapy is to aid them in developing new, more useful and helpful ways of thinking so that they can function more effectively.

9.4.3 Behaviour Techniques

In CBT besides the techniques of cognitive techniques, behaviour techniques are also used. We already discussed cognitive technique under cognitive therapy. We will now discuss about behaviour techniques.

Modelling: The clients are asked to identify someone in their life who they believe has a better way of handling a specific situation. Once they've identified that person, the clients are asked why they think the other person would be better able to handle these situations. Then the clients are asked them to act in the same way that person would behave in the situation and see what happens to their thinking and feeling. The clients are asked to report back at the next session.

Exposure: In this anxieties experienced by the client are to be hierarchical arranged from least to most anxiety provoking situations. The clients are deliberately exposed to increasingly anxiety provoking situations, with an aim to confront the fear instead of avoiding it and are asked to stay with the discomfort till the ultimate goal of becoming desensitised to the triggers is achieved The rationale behind this approach is that with time, the anxiety will subside or disappear through a psychological process of habituation and the associated dysfunctional thought (for example, fear of fainting, or fear of embarrassment) is modified. The exposure may be either real or imaginary. Exposure therapy can be effectively used for obsessive-compulsive disorder and phobias.

Graded task assignments: This technique is used when clients are overwhelmed by a task (by focussing on how far they are from the goal, instead of focusing on their current step) and are unable to handle it. The behavioural goal is broken down that into smaller pieces that can be taken one at a time and help the clients move toward their ultimate goal and as a result it modulates the mood and challenges the appraisal of helplessness.

Activity scheduling: It is a structured method of learning about the clients behavioural patterns, encouraging self monitoring, increasing positive mood and designing strategies for change. A daily or weekly activity log is used in which clients schedule their daily activities on an hour-by-hour basis so that they can use their time more productively and effectively and reap the cognitive and behavioural benefits of doing so.

Reinforcement: These interventions are used mostly to supplement homework assignments .If the clients comply with the primary assignment; they enjoy a mutually agreed upon and appropriate reinforcement. Reinforcement is typically something the client enjoys doing such as reading a book, taking a walk, watching television, and so on. However, if the client does not comply with the primary assignment then a penalty is introduced, which is typically something the client does not enjoy.

Skills training: Clients often lack some social skills either on interpersonal or practical levels that block their ability to reach their goals. The methods employed to train in social skills include, assertiveness training, anger management skills, relaxation skills, behaviour rehearsal etc. Social skills are important for effective management of stress and for building suitable social support.

Relaxation: This has to do with breathing exercise that will help the client relax. The client is often asked to breathe deeply and breathe out gently and focus on his/ her breathing during this exercise. Breathing slowly and regularly at a respiratory rate of 10 to 12 breaths per minute, helps to counter hyperventilation/ or reduce tension. This exercise also helps to distract the client from autonomic cues.

The use of homework between sessions: The use of homework or between-session assignments is essential to CBT. As the main objective of the approach is to help clients make effective and lasting changes in their lives, it is crucial that whatever is being discovered in the sessions be applied in the client's life.

Homework allows clients to test out whatever they have learnt in therapy and creates additional material for further discussion. By specifically having clients do something between sessions, they are being educated to become their own therapist.

Collaborating with clients on assigning the homework increases likelihood that clients would comply with the homework.

Check Your Progress III

1) What is the main goal of Cognitive Behaviour Therapy?

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9.5 RATIONAL EMOTIVE BEHAVIOUR THERAPY

Rational Emotive Behaviour Therapy (REBT) was originally called 'Rational Therapy', soon changed to 'Rational- Emotive Therapy' and again in the early 1990's to 'Rational Emotive Behaviour Therapy'. The basic theory and practice of rational emotive therapy was formulated by Albert Ellis in 1962.

The practice of REBT mainly focuses on emotional-behavioural functioning of humans and how these can be modified if required. The central hypothesis is the concept that not events, but how these events are interpreted by the individual that force people to have emotional behavioural reactions. REBT, also posits that a person's biology also affects their feelings and behaviours as individuals have inborn tendencies to react to events in certain patterns that may not necessarily be influenced by the environmental factors. The

persons belief pattern or system is considered to be influenced by the biological inheritance of the persons as well as his/ her learning throughout life.

9.5.1 ABC Model

Ellis conceptualised ABC model to illustrate the role of cognition on behaviour and emotion. In this ABC model he explained that emotional or behavioural symptoms are consequences (C) that are determined by a person's belief systems (B) regarding particular activating experiences or events (A).

The belief system of an individual may be either "rational" or "irrational".

Rational belief and behaviour is viewed as effective and potentially productive, whereas irrational belief results in unhappiness and non-productivity and leads to many types of emotional problems and stand in the way of achieving goals and purposes of an individual's live. Implicit in the Irrational thinking/belief are the "I must", and "I should" that contribute to the emotional disturbance. For example a person may continually think "I should be thoroughly adequate and competent in everything I do". Such thinking can affect the person negatively and lead to behaviours and emotions that are self defeating and self devaluating. Here is an example of the effect of Rational and Irrational Belief on the emotion and behaviour:

Rational Belief		Irrational Belief	
A)	**Activating event – what happened:** Ms. S fail in her psychology exams	**A)**	**Activating event – what happened:** Ms. S fail in her psychology exams
B)	**Beliefs about A:** It is unfortunate; I will do better	**B)**	**Beliefs about A:** I have to have and A on the exam; I am worthless person because I didn't get an A on the exam
C)	**Reaction :** Emotions : Frustrated because of the performance Behaviour : Choose to study hard for the next exam.	**C)**	**Reaction :** Emotions: Deep despair, a sense of worthlessness Behaviours: Might choose not to study further.

It can be seen in the above table that C is not a direct consequence of A, but B also had played an important role in triggering the behavioural and emotional consequences.

9.5.2 Irrational Beliefs

Ellis identified the following irrational beliefs that might be the root of most psychological maladjustment:

1) I need love and approval from those significant to me – and I must avoid disapproval from any source.
2) To be worthwhile as a person I must achieve, succeed at whatever I do, and make no mistakes.

3) People should always do the right thing. When they behave obnoxiously, unfairly or selfishly, they must be blamed and punished.

4) Things must be the way I want them to be, otherwise life will be intolerable. My unhappiness is caused by things that are outside my control – so there is little I can do to feel any better.

5) My unhappiness is caused by things that are outside my control – so there is little I can do to feel any better.

6) I must worry about things that could be dangerous, unpleasant or frightening – otherwise they might happen.

7) Because they are too much to bear, I must avoid life's difficulties, unpleasantness, and responsibilities.

8) Everyone needs to depend on someone stronger than themselves.

9) Events in my past are the cause of my problems – and they continue to influence my feelings and behaviours now.

10) I should become upset when other people have problems, and feel unhappy when they're sad.

11) I shouldn't have to feel discomfort and pain – I can't stand them and must avoid them at all costs.

12) Every problem should have an ideal solution, and it's intolerable when one can't be found.

Ellis coined the term "musturbation" for all types of must statements. Musturbating develops irrational beliefs and leads to emotional disturbance.

9.5.3 Goals of Rational Emotive Behaviour Therapy

The goal of REBT is to minimise emotional disturbances, decreasing self-defeating self-behaviours, help individuals think more clearly and rationally by restructuring the belief system and self evaluation especially with respect to the irrational "should's", "musts" and "ought's" that prevents a positive sense of self worth and emotionally satisfying life.

9.5.4 Therapeutic Relationship

In REBT techniques like empathy, unconditional acceptance of client, encouragement is used in order to enhance therapeutic relationship. The therapist also has to ensure that the client does not become dependent upon the therapist during the therapeutic process. Therapeutic relation is seen as an important aspect of the therapy in REBT. The therapist plays an active and directive role and teaches the client, how thinking, emotions, and behaviour are interrelated and actively challenge, provoke and dispute the irrational beliefs of the client. The therapeutic relationship is also collaborative. Therapist and client together design homework assignments and develop new ways of thinking.

9.5.5 Therapeutic Process

The core of REBT is the application of the ABC philosophy to the clients' problem. Following this philosophy the process of REBT follows a particular sequence in its therapeutic sessions:

- Defining and agreeing on a target problem for the session.
- Assessing A, the Activating event relevant to the problem. It can

be divided into two parts: what actually happened and what was perceived by the client. Therapist asks about specifics to confirm an activating event as it helps in getting a clear picture. For example an activating event may be presented by the client as 'My marks in psychology exams are terrible', which is actually a combination of perception and evaluation. To ascertain a clear picture therapist might ask 'what are your actual marks in psychology?'

- Assessing C, the consequent emotion. Distinguishing between helpful and self-defeating emotional distress.
- Identifying and assessing secondary emotional problem.
- Assessing Beliefs (B), especially irrational beliefs. Irrational beliefs (IB) causing the unwanted reactions.
- Teaching the client the connection between IBs and self-defeating consequent emotions, the IB-C connection, ensuring that the client sees that their unwanted reaction resulted from their thoughts.
- 'D' that stands for Disputing Irrational beliefs, 'E' that stands for Effect that the client wants to achieve and 'F' that stands for further actions to be taken, are also added to ABC format.
- Disputing ('D') the irrational Beliefs—IBs. Helping the client to dispute their irrational beliefs, using a range of techniques. Replacing beliefs that are agreed to be irrational.
- Deepening conviction in rational alternatives to IBs—rational Beliefs or RBs.
- Effect ('E') once the irrational beliefs are disputed and replaced by rational thoughts, it minimizes the negative emotions while bringing about more satisfying enjoyable feeling.
- Helping the clients put Rational Beliefs into practice ('F'), by developing homework assignments. Identifying and dealing with any potential blocks to completion of the homework.

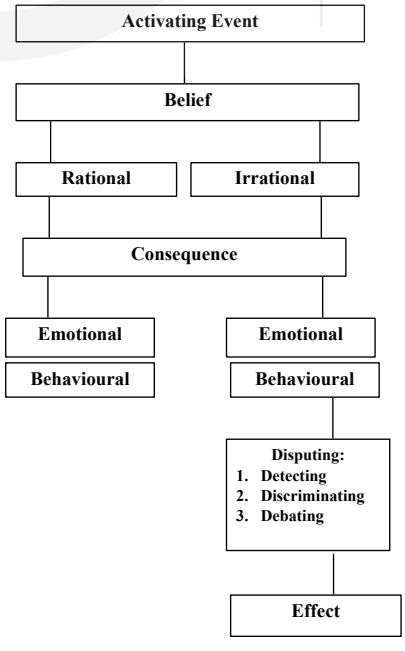

Fig. 9.1: ABCDE Technique

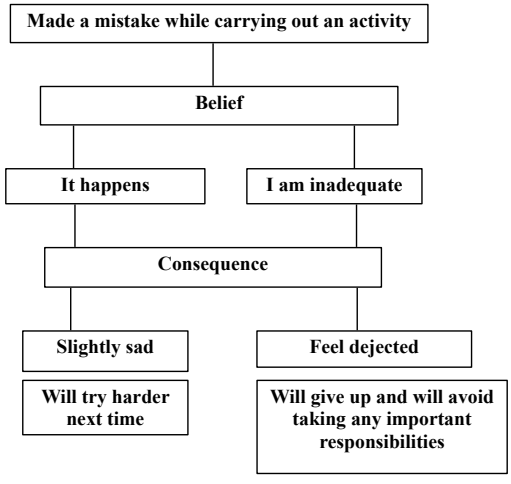

Fig. 9.2: Example of ABCDE Technique

9.5.6 Techniques Used in Rational Emotive Behaviour Therapy

As the name suggests REBT focuses on Cognition, Behaviour and Emotions of the client. These are considered to be interrelated and can have an impact on each other. Let us now discuss the techniques that can be used with regard to these three aspects.

1) Cognitive techniques

The cognitive techniques used in REBT are:

Disputation: Here certain direct questions, logical reasoning and persuasion are used. These are used to challenge and dispute the irrational beliefs displayed by the client.

Coping self- Statements: This technique can be used in order to strengthen rational beliefs For example A person who wants to get nothing less than a distinction in his/ her examination may write down and repeat "I want to score a distinction but it is alright if I don't.

Reframing: In this the negative events are re-evaluated. For example instead of calling an inability to speak in public as awful, it is termed as uncomfortable. This will help client understand that even negative events can be perceived in a positive light. This is done mainly by asking the client positive aspects of a negative event. If for example the negative event is inability of the client to speak in public, the client will list the advantages of this negative event, like; the client can say that at least he/ she came to know about what area he/she can improve upon.

Double-standard dispute: As the name suggests this helps the client realise about his/ her double standards about his/her beliefs. For example, if the client feels that the fact that he she failed to make a good presentation in office proves that he/she is miserable and good for nothing, he/ she is asked about what he/she would say if his/her friend had done the same thing. Would they term their friend as miserable and good for nothing, if the answer is 'No' then the client is made conscious about his/ her double standards. This can especially be used effectively with certain resistant beliefs displayed by the client.

Catastrophe scale: This is a useful technique to get awfulising into perspective. A vertical line is drawn on a sheet of paper and marked 100% at the top, 0% at the bottom, and 10% intervals in between. Once this is done, the client then has to rate the situation, object, items etc. that they are

catastrophising about and insert those items in to an appropriate place on the chart. Such an exercise is repeated with other items as well. For example, at 0% - 'Having a quiet cup of coffee at home', 20% - 'Having to clean the house when there is a cricket match on television', 70% - being burgled, 90% - being diagnosed with cancer, 100% - being burned alive, and so on. Then the client compares the rating of the feared item with the rating of other items and may realise that he/she was exaggerating the badness involved in the feared item. Thereafter the client move the item down the list until it is in perspective in relation to the other items.

Devil's advocate: Also known as reverse role-playing. In this the therapist role plays the client's belief and vigorously argues in its favour whereas the client tries to 'convince' the therapist that the belief is dysfunctional. This technique is useful when the client has developed an understanding that, but requires help in order to consolidate that understanding.

2) Emotive techniques

The emotive techniques used in REBT are:

Time projection: This technique is used to explain and show to the clients that one's life, and the world in general, continues even after an occurrence of feared or unwanted incident. The clients are asked to visualise the unwanted event occurring, then imagining going forward in time from a week, to a month, to six months, then in a year, two years, and so on, considering how they would feel at each of these points in time. This enables the client to understand that life goes on, even though they may need to make certain adjustments.

Rational- emotive imagery: This can be termed as a type of mental practice. In this the client is asked to imagine situation that is negatively perceived by the client and that would bring out negative feelings in the client. Once these feeling are experienced by the client they are changed to more positive and appropriate feelings. The client keeps practicing such a procedure 'several times a week for a few weeks' then reaches a point where he/she is no longer troubled by the event.

Procedure	Example
Imagine, vividly and clearly, the event or situation with which you have trouble.	You have to inform a colleague that his request for promotion has been turned down due to poor performance record.
Allow yourself to feel - strongly- the self-defeating emotion which follows.	Anxiety
Note the thoughts creating that emotion	He will be upset. I couldn't stand feeling responsible. I must find a way to say it without him getting upset.
Force the emotion to change to a more functional (but realistic)feeling. It is possible to do this, even though briefly.	Concern
Practice the technique daily for a while.	It will be uncomfortable, but it won't kill me. While I would prefer him not to get upset, his emotions are his responsibility - I cannot control his feelings or be responsible for them.

3) Behavioural techniques

The behavioural techniques used in REBT are:

Exposure: Exposure is one of the most frequently used behaviour techniques in REBT. In this the client is encouraged to face or experience the situation that he/ she fears the most and would otherwise avoid. The exposure is panned and involves use of cognitive and coping skills. This technique is carried out with the purpose of testing the validity of the client's fear, de-awfulising the fear and developing the confidence of client in his/her coping skills and to increase the discomfort experienced by the client.

Shame-attacking exercises: This technique involves confrontation by the client of his/ her fear of shame. It involves behaviour of the client in such a way that attracts disapproval. Use of this technique will lead to increase in tolerance for discomfort. It will also lead to reduction of concern about being disapproved and will increase the client's ability to take risk. For example: wearing loud or unmatched clothes (if the client is obsessed about dressing or appearance), asking a silly question at a lecture (face the fear of being seen as stupid). Through this the client learns that the world does not stop even if a mistake is made and everything need not be perfect.

Paradoxical behaviour: This technique is often used in order to deal with or modify dysfunctional tendencies. In this the client is encouraged to behave in way that is contrary to the tendency. For example, a perfectionist person could deliberately do some things that are less than his usual standard.

Postponing gratification: This particular technique can be effectively used in order to deal with low frustration tolerance. This is done by delaying gratification that a person might get by for example, smoking, eating sweets, consuming alcohol etc.

Bibliotherapy: In this client is asked to read a self-help book.

Activity homework: The therapists assign homework activities to the clients in order to combat their 'demands' and 'musts' and reduce their irrational beliefs. For example rather than quitting a job a client may continue to work with unreasonable boss and listen to the unfair criticism and mentally dispute the criticism and not accept the boss's belief as their own irrational beliefs. Initially the clients may feel anxious or self-conscious but are able to comprehend the irrational beliefs underlying their emotions.

Check Your Progress IV

1) What is ABC model?

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9.6 LET US SUM UP

In the present unit we discussed about behaviour modification, cognitive therapy, Cognitive Behaviour Therapy and Rational Emotive Behaviour Therapy. Behaviour modification can be described as an approach to psychotherapy which is based on learning theory and aims to address the client's problems through techniques designed to reinforce desired and

eliminate undesired behaviours. And the cognitive oriented therapies, that is cognitive therapy, CBT and REBT focus on how thinking pattern can have an impact on an individual. We also dealt with the goals and various techniques under these therapies. While comparing cognitive therapy, CBT and REBT, one of the similarities between the three therapies is that they deal with the beliefs of the client and seek in a way to modify the belief system of the client. CBT also focuses further on behaviour and REBT focuses on both behaviour and emotions. In cognitive therapy and CBT the cognitive distortions are focused on. Whereas in REBT, ABCDE technique is used in order to help client deal with his/ her irrational beliefs. With regard to cognitive therapy, the techniques used by a therapist will depend on the disorder of the client. However in REBT same approach is used for various disorders. In all the three therapies, the therapeutic relationship is relevant and therapist plays an active and important role.

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9.8 KEY WORDS

ABC model: Ellis conceptualised ABC model to illustrate the role of cognition on behaviour and emotion. In this ABC model he explained that emotional or behavioural symptoms are consequences (C) that are determined by a person's belief systems (B) regarding particular activating experiences or events (A).

Behaviour modification: Behaviour modification can be described as an approach to psychotherapy which is based on learning theory and aims to address the client's problems through techniques designed to reinforce desired and eliminate undesired behaviours.

Biofeedback: Biofeedback is a method that provides immediate feedback on a person's physiological state, be it heart rate, breathing rate or blood pressure.

Systematic desensitisation: Systematic desensitisation is a behaviour modification practice used to eliminate fears or undesirable emotions. It is based on the classical conditioning principles of pairing anxiety provoking stimulus/event with a relaxation response. Exposure to the fear-producing stimuli while focusing on relaxation techniques eventually leads to the fear-inducing stimuli resulting in the relaxation response, rather than fear.

The cognitive model: The cognitive model, hypothesises that individuals' emotions, behaviours, and physiology are influenced by their perception of events. The situation in itself does not determine the reaction and feeling of the individuals' rather it is associated with how they perceive and interpret the situation which is expressed in "Automatic Thoughts"

9.9 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress I

1) What is behaviour modification?

Behaviour modification can be described as an approach to psychotherapy which is based on learning theory and aims to address the client's problems through techniques designed to reinforce desired and eliminate undesired behaviours.

Check Your Progress II

1) List any two cognitives techniques.

Labelling distortions and decatastrophizing are two cognitive techniques

Check Your Progress III

What is the main goal of Cognitive Behaviour Therapy?

The main goals of CBT are to help clients identify, inspect, challenge and argue the beliefs and thinking in present that is affecting them in a negative manner.

Check Your Progress IV

1) What is ABC model?

Ellis conceptualised ABC model to illustrate the role of cognition on behaviour and emotion. In this ABC model he explained that emotional or behavioural symptoms are consequences (C) that are determined by a person's belief systems (B) regarding particular activating experiences or events (A).

9.10 UNIT END QUESTIONS

1) Discuss the principles and techniques of behaviour modification.
2) What are the principles of Cognitive Behaviour Therapy?
3) Explain the components of cognitive model.
4) What are the common cognitive biases? How do they originate?
5) Explain the ABC model of REBT.