Topic Page: Cognitive Behvioral Therapy

Summary Article: **Cognitive Behavioral Therapy**
from *Cultural Sociology of Mental Illness: An A-to-Z Guide*

Cognitive behavioral therapy (CBT) is an effective and popular type of therapy for a wide range of mental health and other issues. Therapists use CBT to assist clients in managing their problems through changing how they think (cognitive) and act (behavioral) toward themselves and their situation. CBT often attempts to replace maladaptive emotions, thinking styles, and behaviors with normative ways that promote health and well-being. CBT can be used for a range of issues and is particularly useful for dealing with anxiety, depression, drug misuse, and eating disorders.

The term *cognitive behavioral therapy* refers to the development of integration in the late 1980s and early 1990s of two types of therapy, behavior therapy and cognitive therapy. Behavior therapy was developed in the 1950s and 1960s, a behavior change approach based on learning alternative behaviors through either reinforcement of desirable behaviors or elimination of undesirable behaviors. Behavior therapy was influenced by the behaviorist movement in academic psychology, such as classical conditioning and operant learning theories, and therefore is based on the premise that problems represent learned behavior patterns that are modifiable by reinforcement, management, or coping skills training. Behavioral therapy is regarded by some therapists as the first wave of CBT because it was a major breakthrough in the 1950s and 1960s in the psychological treatment of mental health problems, and it was a revolutionary challenge to psychoanalytic therapy, the dominant therapy at that time.

While behavior therapy continues to be an important component of CBT today, therapists were dissatisfied with its limitations, especially the downplay of mental processes (cognitions) such as beliefs, interpretations, and thoughts that behaviorists claimed were not directly amenable or observable in scientific studies. An intellectual movement in the late 1960s—known as the “cognitive revolution,” or second wave of CBT—resulted in greater appreciation of cognition in psychology and therapy, especially their interaction with emotion and behavior. This led to the development of cognitive therapy, which focuses on how distorted and maladaptive thoughts underpin behavioral dysfunction. Historical accounts of cognitive therapy typically cite Albert Ellis and Aaron T. Beck as its original founders in the 1960s. Ellis developed rational emotive behavior therapy (known previously as rational therapy and rational emotive therapy), which is one the first forms of CBT and is based on the ABC model. Beck's approach to cognitive therapy is cognitive restructuring, which teaches clients to identify and modify negative automatic thoughts, dysfunctional assumptions, and negative self-statements, thereby changing behavior.

Behavior and cognitive therapies have proven effective across a variety of presenting concerns and psychological conditions. In the 1980s and 1990s, behavior and cognitive techniques developed together and became incorporated in an integrated cognitive behavioral model known now as CBT. During the past 10 to 15 years, some new treatments have been developed that represent a significant departure from these assumptions, many of which incorporate acceptance and mindfulness techniques, the third wave of CBT. Not all researchers and therapists describe the development of CBT as distinct stages, but rather as gradual advancement.

Applications

CBT can be an effective treatment of a wide range of presenting concerns, especially mental health

issues such as anxiety and stress, depression, eating disorders, drug and alcohol problems, personality disorders, phobias, obsessive-compulsive disorder (OCD), post-traumatic stress disorder, bipolar disorder, and psychosis. Also, CBT can be an effective therapy for physical health problems through changing client's perceptions of illness and medical conditions.

CBT is usually a one-to-one therapy but is also offered in group sessions and in self-help applications such as computer-based therapy (computerized cognitive behavioral therapy, CCBT) for delivering CBT via a personal computer. Effective CBT is partly dependent on a collaborative relationship between client and therapist, who work together so that the client is actively involved in therapy rather than dependent on the therapist.

At the beginning of a CBT program, the client and therapist meet to explore the client's reasons for seeking treatment and their readiness to change, and the therapist introduces CBT. The therapist then formulates a treatment plan to address specific target behaviors and antecedents. In subsequent sessions, the therapist helps the client to change unhelpful thoughts and behaviors. CBT sessions tend to follow a structure and begin with agenda setting to decide main topics to work on, review of previous sessions, and review of homework, the tasks that the client conducts between sessions. The number of required CBT sessions depends on the nature of the problem and the client's suitability for CBT, and typically range 12 to 20 weeks, with client and therapist meeting once per week. Sessions tend to be offered in a series of blocks, followed by review.

Although the combination of behavior therapy and cognitive therapy is regarded as the mainstream definition and theoretical foundation of CBT, there is no singular approach because CBT refers to a family of related therapies that represent diverse theories and practices that differ in both minor and major ways, some of which are quite distinct.

Strengths and Weaknesses

CBT has strengths and weaknesses. It is a popular and effective treatment for a broad range of problems, and it has a flexible and individualized approach that can be used for a wide range of clients, settings, and problems. However, CBT is not suitable for everyone, and its broadness means that CBT treatments can widely vary.

CBT is an evidence-based therapy and has been subjected to high-quality research and evaluation, including randomized controlled trials. Though research points to CBT as an effective treatment, the full extent of efficacy remains unclear and debatable because there is a paucity of research and evaluation of some types of CBT, such as long-term treatment and third-wave therapies. Another challenge is the meaning of evidence and how it is used in the reality of everyday practice of CBT; mainstream CBT is aligned with the medical model, and treatment is viewed as analogous to drug treatment, which has been criticized by sociologists.

Cognitive behavioral therapy (CBT) is usually conducted one-to-one. Initially, the client and therapist meet to explore the client's reasons for seeking treatment and their readiness to change and the therapist introduces CBT and formulates a treatment plan. During sessions, which typically range over 12 to 20 weeks, the therapist helps the client to change unhelpful thoughts and behaviors.

This is set against a backdrop of discontent with the medicalization of society, whereby conditions and problems—even normal life events—have come to be defined and treated as medical problems with diagnoses and treatments, thereby fuelling the growth and professional jurisdiction of CBT while overlooking the social construction of mental health and its determinants such as beliefs, social conditions, structures, and processes. While procedures such as randomized controlled trials are indispensible for evaluation of CBT, sociologists are keen to explore a broader evidence base. A development has been a social constructivism approach in CBT, which respects the ways that people construe life differently according to their culture and society, and assumes that social systems and society underpin people's problems. Therefore, social constructionist versions of CBT place less emphasis on distorted and irrational thinking in favor of the value of the therapeutic relationship. However, constructivism has been criticized by realists who question its violation of the basic principles of CBT and view it as an “anything goes” therapy.

Another issue is applicability of CBT across cultures and minority groups. Traditional CBT and counseling theories and approaches were developed in the West where the profession is established. CBT in other countries has Western characteristics, which may be less relevant to ethnic minorities and might even produce negative outcomes. However, relatively little is known about the efficacy of CBT for people from diverse ethnic and cultural backgrounds, and culture is difficult to define because clients describe their ethnicity and degree of participation in ethnic communities in different ways. Therapies such as CBT should be used with care, especially with clients in non-Western cultures, and this is also an important issue for counselors in developed countries such as the United States with diverse communities. Another issue is that members of minority groups may encounter barriers to treatment

such as discrimination, lack of knowledge, poor language skills, isolation, poverty, lack of trust in the medical system, stigma-related concerns, and other social, economic, and cultural barriers, and therefore use fewer counseling services. There is wide variation across countries in availability of CBT. In many low-income and middle-income countries, access is limited, particularly in rural areas.

These debates further justify sociological studies on CBT and the interplay between society and mental health to shed light on CBT and its interaction with therapists, and the social spheres in which they are embedded.

See Also: Anthropology Clinical Sociology Diagnosis Diagnosis in Cross-National Context Medicalization, Sociology of Randomized Controlled Trial

Further Readings

- Beck, Judith. Cognitive Behavior Therapy: Basics and Beyond. Guilford Press New York, 2011.
- Hays, Pamela; Gayle Iwamasa. Culturally Responsive Cognitive-Behavioral Therapy: Assessment, Practice, and Supervision. American Psychological Association Washington, DC, 2006. doi:10.1037/11433-000.
- Neimeyer, Robert. Constructivist Psychotherapy: Distinctive Features. Routledge New York, 2009.

Gareth Davey
Hong Kong Shue Yan University

APA

Chicago

Harvard

MLA

Davey, G. (2014). Cognitive behavioral therapy. In A. Scull (Ed.), *Cultural sociology of mental illness: an A-to-Z guide*. Thousand Oaks, CA: Sage Publications. Retrieved from https://search.credoreference.com/content/topic/cognitive_behvioral_therapy

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Davey, G. (2014). Cognitive behavioral therapy. In A. Scull (Ed.), *Cultural sociology of mental illness: an A-to-Z guide*. Thousand Oaks, CA: Sage Publications. Retrieved from https://search.credoreference.com/content/topic/cognitive_behvioral_therapy

Chicago

Davey, Gareth. "Cognitive Behavioral Therapy." In *Cultural Sociology of Mental Illness: An A-to-Z Guide*, edited by Andrew Scull. Sage Publications, 2014. https://search.credoreference.com/content/topic/cognitive_behvioral_therapy

Harvard

Davey, G. (2014). Cognitive behavioral therapy. In A. Scull (Ed.), *Cultural sociology of mental illness: an A-to-Z guide*. [Online]. Thousand Oaks: Sage Publications. Available from: https://search.credoreference.com/content/topic/cognitive_behvioral_therapy [Accessed 19 May 2019].

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