Cognitive Interventions

Cognitive interventions are those that target thoughts. They include psycho-education about thoughts and beliefs; identification and challenging of negative automatic thoughts (NATS) via cognitive restructuring; and schema therapy. Cognitive techniques are often the focus in clients presenting with anxiety.

Psycho-Education

Psycho-education is an important part of CBT, with the therapist being seen as a source of expert information that they can 'teach' to the client. Key elements in this might be teaching clients about:

- the difference between a thought and a fact (designed to help clients see that they don't have to believe that all their thoughts are true)
- how our interpretation of reality affects our thoughts (i.e. the role of phenomenology in how we view situations)
- the function of thoughts and beliefs (based on human evolution and survival instincts)
- the commonality of human thinking (so normalising thought types and patterns that the client might otherwise feel alone in experiencing).

Negative Automatic Thoughts (NATs)

Many people find themselves falling into the trap of NATs. Common categories of these include:

- ***overgeneralisation* –** coming to a conclusion based on a single event or one piece of evidence (e.g. I was late for work today; I am useless)
- ***filtering*** – concentrating on the negative events while ignoring the positives in life (e.g. I know my tutor said most of my assignment was great but he also said there were a number of spelling mistakes that needed correction; he must think I am stupid)
- ***all-or-nothing thinking* – t**hinking in extremes, sometimes referred to as 'black-and-white thinking', with no middle-ground perspective (e.g. I have painted the wall but have dripped a couple of paint spots on the floor; I might as well not bother doing it again)
- ***personalising* –** thinking that other people's reactions or events that happened must be down to your actions (e.g. Yvonne is in a bad mood; it must be because of something I said or did)
- ***catastrophising* – e**xpecting that something will always go wrong (e.g. if I drive my car, I am bound to have an accident)
- ***emotional reasoning* – assuming that your thoughts are facts** (e.g. I feel like a failure; therefore, I must be a failure)
- *m**ind reading* – j**umping to conclusions rather than gaining your opinion from facts (e.g. Anna is spending more time with Molly; she must like her more than me)
- ***fortune-telling*** – predicting an outcome and assuming your assumptions are established facts (e.g. it's always been like this; I will never be able to change)
- ***should statements* –** using the words 'should', 'must' and 'have to' all the time, and so being rigid and inflexible in thinking (e.g. people should be nice to me all the time)
- ***magnification/minimisation* – e**xaggerating the importance of negative things while dismissing or reducing the positive elements in life (e.g. I am seeing my friend tonight, to help her with college work; I bet she remembers the time that we fell out).

Cognitive Restructuring

Beck described NATs as a stream of thoughts that we can become aware of if we acknowledge them. The therapist examines specific situations in which the client has found themselves, asking open questions such as:

- What was going through your mind at that time?
- What did the situation mean for you?
- How did your thinking affect you?
- What evidence is there for and against the underlying beliefs?
- Are there any other possible explanations?
- What would you tell a friend or relative who saw the situation like this?
- What could be the effect of changing your thinking?
- What could you do now/next time this happens?

Clients may complete a thought log/record either at home or during the session. This aims to challenge irrational thoughts, weighing up evidence for and against, and to replace these with alternative balanced thoughts.

Core Beliefs/Schemas

Young et al. (2006) suggested that many of our negative cognitions are rooted in early childhood experiences, innate temperaments and/or cultural influences. For example, clients' psychological wellbeing could have been damaged in their childhood years by not having their needs met, being traumatised or victimised by a controlling adult, absorbing a schema from an influential adult who themselves had a strong schema, or being overprotected and excessively indulged.

The resulting maladaptive cognitions (known as core beliefs or schemas) are often unconditional and very deep-rooted, having become a core part of the person's self-concept. Because of their longevity and deep-rootedness – and their being stored in the amygdala (a part of the brain that is not amenable to logical analysis) – they are difficult or even impossible to work with using cognitive restructuring alone. Many schemas are acquired before the child is fully able to communicate verbally – these are particularly hard to shift. Other schemas (i.e. those acquired later) are sometimes known as conditional schemas, as they are less deep-rooted. However, whichever their origin and longevity, schemas are stable and enduring patterns, based on an idiosyncratic mix of cognitions (including memories, in both verbal and image forms).

Through 15 years' clinical observational practice, Young and his colleagues (2006) proposed that there are five domains of such maladaptive early schemas (which relate to childhood needs), containing a total of 18 schemas:

1. disconnection and rejection (comprising the schemas of abandonment, mistrust/abuse, emotional deprivation, defectiveness/shame, and social isolation);
2. impaired autonomy and performance (dependence, vulnerability, enmeshment, and failure);
3. impaired limits (entitlement, and insufficient self-control/self-discipline;
4. other-directedness (subjugation, self-sacrifice and approval-seeking); and
5. overvigilance and inhibition (negativity, emotional inhibition, unrelenting standards, and punitiveness).

Schemas can be identified in clients through comprehensive assessment, using Young's schema questionnaire. Another technique involves asking the client to close their eyes and create an image of themselves as children with their parents.

To return to the examples above, a client who had not got their childhood needs met might have acquired an emotional deprivation schema; one who had been victimised could have a mistrust/abuse schema; one who had been influenced by an adult with a punitiveness schema could have adopted the same; and one who was spoilt could have become an adult with an entitlement schema.

Because adults with schemas have become locked into maintenance cycles that keep these going, they tend to live in ways that unconsciously perpetuate them. Paradoxically, the schemas become so familiar that they are comfortable to stay stuck in, meaning that people may live with them for many years before some precipitating factors triggers an acute problem that leads to therapy – and so the discovery and possibility of treating the schema. People may live with schemas using any of three possible strategies: surrender (giving in to and going with the schema), avoidance (avoiding situations that highlights the schema's existence) or overcompensation (behaving in an extreme opposite way to what the schema would suggest).

Warning signs that schemas may be present in a client include them feeling pervasively stuck, inadequate, lonely, numb to their emotions or as if life has no meaning – or behaving in a way that involves depending on others or having problems choosing appropriate partners. Presenting problems such as long-term eating disorders, substance abuse, chronic depression and other repetitive patterns of behaviour may also be clues to the existence of an underlying schema.

Schema Therapy

It is important as a therapist to remember and to respect that a client may not wish or be ready to heal their schema(s) and rules for living. Indeed, tackling schemas in a very time-limited course of therapy – or if these emerge towards the end of a finite number of sessions – may not be in the client's best interests, as this is particularly deep and challenging work for both client and therapist.

But if schema therapy does seem to be both desired by the client and safe within the counselling context, then various methods are used to treat schemas. These include identifying schemas and how they relate to the client's presenting problem (through developing a formulation and psycho-educating the client on how the different elements in this link, and are perpetuated via maintenance cycles) – and then working on dysfunctional beliefs and behaviours. It is important to break down tasks into small steps that feel manageable to the client. Practising the core conditions – and so meeting the client's emotional needs of us as therapists – is also an important form of modelling health patterns of relating.

For example, techniques that can be used to help clients heal schemas can be emotive (e.g. empty chair work and unsent letters), interpersonal (perhaps using immediacy and congruence to highlight how we experience the client in relationship, or involving their partner in therapy), cognitive (through examining evidence for and against, and creating a more balanced alternative thought – if the schema is amenable to this – perhaps recorded on a flashcard for regular reminders) and/or behavioural (perhaps practised using in-session role play if possible, e.g. to train in enhanced communication skills and practise dialogues that the client plans to instigate with key people in their life).

Reference

Young J, Klosko J & Weishaar M (2006) Schema Therapy: A Practitioner's Guide, Guilford Press