Mini Review

Behavioral therapy and cognitive behavior therapy

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ABSTRACT

Cognitive-behavioral techniques have developed into the most thoroughly investigated psychological treatments for a wide range of illnesses since the advent of Beck's cognitive theory of emotional disorders and the treatment of those disorders with psychotherapy. Despite this, there is much disagreement on the relative contributions of cognitive and behavioural treatment modalities, as well as the mechanistic function of cognitive change in therapy. We conduct a critical assessment of the research in this area, concentrating on the mechanistic relevance of cognitive change in cognitive and behavioural treatments for anxiety and depressive disorders

Keywords: Emotional disorders; Psychotherapy; CBT; Treatment; Anxiety

INTRODUCTION

The introduction of behavioural treatments for psychopathology in the 1950's and, later, the so-called "cognitive revolution" of the 1950's and 1960's can be linked to the development of Cognitive Behavioral Therapies (CBTs) as a family of interventions. Therefore, CBTs include methods that are stressed in Cognitive Treatments (CTs) and Behavioural Therapies (BTs). Regarding the relative contributions of CT methods to BT strategies in encouraging symptom change within CBTs, there is still uncertainty, nonetheless. Additionally, opponents have questioned whether the "cognitive" aspect of cognitive-behavioral therapy contributes in any way, claiming that changes in thinking are not processes of change in CBTs. Despite disagreement over their operating and active therapeutic components CBTs are still the most extensively researched kind of therapy. CBTs have a particularly enticing feature in that their theories of the majority of contemporary conceptualizations of psychopathology are compatible with therapeutic treatment [1].

LITERATURE REVIEW

In this review, we make an effort to resolve disagreements on the relative importance of CT. Strategies for BT, as well as the processes underlying their effectiveness. We start by offering a very brief historical outline of CBT's beginnings and discussion of the cognitive therapy's support models of susceptibility to anxiety and depression illnesses. We talk about methodological difficulties that have prevented a more full knowledge of the relative merits of various theories in psychotherapy research contributions of behavioural and cognitive methods. The majority of the discussion after that is subsequently devoted to studies on the cognitive mechanisms of change in Cognitive Therapy (CT, BT, and CBT) for depression and anxiety disorders. We refer to therapist activities that are intended to alter the content or method of ideas, inferences, interpretations, cognitive biases, and cognitive schemas as Cognitive Therapy (CT) and cognitive procedures. Socratic questioning, weighing the pros and cons of beliefs, cognitive rewiring, and embracing different basic beliefs are some of these therapies. We refer to the actions taken by therapists to change observable behaviour as Behaviour Therapy (BT) and behavioural approaches [2]. These actions include *in vivo* exposure, imaginal exposure, and activity scheduling. When referring to a treatment plan that integrates cognitive and behavioural procedures, we refer to it as a Cognitive Behavioral Therapy (CBT) in the singular and as a family of interventions (CBTs) in the plural. We define cognitive transformation as modifications to the substance of ideas, assumptions, interpretations, and cognitive biases. When we talk about behavioural changes, we mean shifts in behaviour like increasing the frequency of certain behaviours or decreasing the

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frequency of others. We discuss issues with conceptualising and measuring cognitive *vs.* behavioural interventions as well as cognitive *vs.* behavioural mechanisms of change in our paper. We conclude with a summary and suggestions for further study. In the 1950's and 1960's, behavioural therapies first appeared [3]. The behavioural models highlighted self-sustaining behaviours and maladaptive learning as being crucial to maintaining psychopathology. As a result, behavioural transformation became the clear therapeutic goal—a radical departure from the predominate psychoanalytic models. Pathological behaviour was seen in psychoanalysis to represent dysfunction in underlying psychological systems. Therefore, behavioural modification was viewed as a "symptom reduction" at the surface level that failed to address underlying issues. BTs proven to be quite successful, especially in the treatment of phobias and more specific forms of anxiety [4]. The effectiveness of these interventions was explained using the concepts of associative learning. A clear change in behaviour (such as approaching a previously avoided stimuli) in the absence of symptoms was the behaviourists' definition of learning (e.g., without displaying the fear reaction). This explanation steered clear of "mentalistic" words. Early behavioural models included theoretical explanations that were primarily concerned with associative learning, but non-associative learning, such as habituation, was also seen to be significant. Inhibitory learning is also a focus of more recent behavioural models. Ellis, who established a type of therapy known as rational-emotive therapy, and Beck's writings on the subject of therapy led to the development of Cognitive Therapy (CT) within the context of the so-called cognitive revolution. The inference errors that result in maladaptive beliefs of oneself, the world, and the future were the main focus of Ellis and Beck's cognitive theories. According to Beck, the activation of cognitive schemas which normally form early in life leads to the development of cognitive biases and maladaptive cognitive content. CTs were concentrated on depressotypic presentations and more generalised fear, in contrast to BTs, which were first successful in specific phobias and restricted worries. Early on in his writing, Beck became aware of the differences between his cognitive theory of psychopathology and behavioural theories of psychopathology, which emphasised the importance of cognition in the aetiology of illness. He discusses cognitive therapy's nature and relationship to behavioural treatment in his widely read article. The fact that both therapies are symptom-focused, deal with difficulties in the present, and demand active therapist involvement are similarities. According to Beck, behavioural and cognitive approaches differ from one another. He used the tenets of his at the time developing cognitive theory to explain the mechanisms of systematic desensitisation, a BT [5]. The cognitive model, in his opinion, "provides a larger variety of concepts for describing psychopathology as well as the mode of action of therapy," he said in his conclusion. In order to provide a cognitive explanation of the consequences of a behavioural intervention, Beck distinguished between the type of therapeutic treatments (*i.e.,* cognitive *vs.* behavioural) and their underlying mechanisms. One of the earliest analyses of the relative contributions of cognitive and behavioural strategies and the pertinent mechanisms of change would be Beck's article. Beck has updated his cognitive model twice, but its core principles that different types of psychopathology can be distinguished by differences in the location of the cognitive pathology, and that cognitive change is essential to symptom change regardless of how it is attained remain largely unaltered [6]. The idea that cognitive weaknesses increase risk for the development and maintenance of psychopathology is supported by basic research. The aetiology of anxiety disorders has been linked to overestimation of threat and attentional biases to threatening cues. Negative biases in the evaluation of life events, symmetric memory for negative *vs.* neutral or positive information, difficulties disengaging from negative material, sustained or symmetrical attention to negative, relative to positive, stimuli, negative biases in the appraisal of life events, and negative schemas about the self that encourage maladaptive and negative thinking are all biases associated with depression. In general, research to date supports theories of affective disorders with cognitive vulnerability. For instance, cross-cultural research consistently indicates that healthy people tend to have a bias toward optimism, which is not present in people who are depressed and who instead tend to have a leaning toward more pessimistic thinking. Comparatively to non-anxious individuals, anxious participants are biased to attend to dangerous stimuli (d=0.45), according to a meta-analytic assessment of 172 research looking at biases towards threatening stimuli. Because the majority of the early research on this topic was correlational in nature, the causal relevance of these cognitive vulnerabilities, particularly in depression, has been called into question [7].

DESCRIPTION

However, results from prospective research also back up cognitive models. For instance, even when taking into account previous levels of automatic thought activity, daily variations in negative automatic thoughts have been found to predict subsequent poor mood. Depressed mood after a stressor is also predicted by negative dysfunctional attitudes. In one study, participants who were categorized as having a high cognitive risk had a nearly 7-fold higher likelihood than participants categorized as having a low risk of reporting a severe depressive episode at the 2.5 years follow-up. Prospective studies offer a higher level of causality proof than correlational research, but the results from these studies are still influenced by third variable confounds, making experimental designs desirable. There have been very few experiments that manipulate cognitions and evaluate how the alteration affects mood. However, the outcomes of these tests are in line with theories of cognitive vulnerability. For instance, Mathews and Mackintosh found that a series of experiments showed that biassing people to perceive ambiguous information as dangerous increased state anxiety. Another study modified information that was emotionally upsetting to draw attention to it [8]. Participants who had their attention directed toward negatively valenced stimuli after a stressful activity displayed higher levels of anxiety and despair than those in the control group. Given that cognitive biases raise the probability of depressive and anxious states, measures that address these biases should lower risk. Basic studies on emotion control lend credence to this notion. The biggest effect (d=0.45) was linked to strategies that promote rational perspective-taking, as is emphasised in CT. Studies that look at the biological vulnerabilities to negative emotional states suggest that, at the phenomenological level, biological vulnerabilities make people more likely to experience negative emotional states by impeding their capacity to engage in cognitive reappraisal strategies. This finding lends even more support for cognitive theories. It is necessary to conduct further study, particularly experimental research, to better understand the nature of the cognitive biases linked to depression and anxiety [9]. Theories of psychopathology must take into account

the bidirectional link between affective disorders and cognition. However, it can be argued with confidence that the cognitive model is an accurate description of the aetiology of affective disorders given the volume of evidence and the lack of other explanations. Therefore, there should be a lot of evidence to support the claim that, in the context of psychotherapy, a change in cognition mediates a change in symptom. Instead, questions about whether "we need to challenge thoughts in cognitive behaviour therapy?" can be found in the literature and statements like "whatever the basis of alterations with CT, it does not seem to be the cognitions as originally proposed," among others. What causes this?

CONCLUSION

Characterizing the process of change in psychotherapy is extremely difficult, as has been widely emphasised. A specific therapeutic package will advocate a set of therapeutic techniques within a therapeutic orientation, such as increasing motivation for behavioural change. Some of these techniques may overlap with those of other therapeutic packages, either inside or outside of that orientation. The relationship between particular treatments and improvement may be muddled by factors shared by other interventions, which may also cause a change in symptoms. Additionally, a particular method may have an impact on a psychological mechanism other than the one(s) it is intended to target, instead of the one(s) it is targeting. A psychotherapeutic approach, according to Beck, is not a disjointed set of treatments but rather a series of steps that stem from "a comprehensive theory of psychopathology that articulates with the structure of psychotherapy." The theory of the sickness or pathological process in question should therefore be connected to any useful considerations of a procedure's effectiveness or validity. Insofar as they are accompanied by an alternative theory, ideas, and evidence addressing alternative non-cognitive mechanisms of change, critiques of a cognitive model of the emergence, maintenance, and resolution of psychopathology will advance the topic. In our opinion, often cited critiques of the theoretical framework supporting CBTs have oversimplified the framework. The data available across the sciences supports cognitive models that contend that some people are more predisposed than others to being exposed to adverse environmental cues, less predisposed to being exposed to favourable cues, or more predisposed to paying attention preferentially to adverse information. These people are more prone to suffer distress in stressful situations and are less likely to use the kinds of self-reflection and coping mechanisms that might result in a naturalistic recovery. The use of cognitive and behavioural therapies is an effort to make use of these resources. Because CT exercises are frequently utilised before and after behavioural exercises and vice versa, it is rather artificial to distinguish between behavioural and cognitive change tactics and processes. Furthermore, even when taken into account in certain settings, the relative effectiveness of different approaches does not offer conclusive proof of mechanisms. The most economical explanation of the change brought about by psychotherapy to date emphasises the significance of modifications to cognitive structures or contents. A compelling, empirically supported alternative theory of change has not yet materialized, despite the research literature's limited capacity to give robust confirmations of the causal hypotheses incorporated in cognitive theories of change.

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