The Use of Cognitive-Behavior Therapy in Social Work Practice

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Social workers play many roles in the lives of their clients. They are counselors, case workers, placement finders, employment directors, communicators, mediators. How do they do it all? How do they meet each client's specific needs? They follow their values and the Code of Ethics. They also use theories from fields such as sociology, psychology, etc. to help their clients. Each theory they use can be implemented to help that specific client's needs. One theory that is popularly used is Cognitive-Behavior Therapy. It's used to primarily help clients with anxiety disorders, depression, trauma-focused disorders, etc. (Psychology, 2017).

CBT, as its abbreviated, was created by Dr. Aaron Beck in the 1960s. Beck was a psychiatrist at the University of Pennsylvania when he founded his theory which later marked him as the "father of CBT" in history (Institute, 2019). He was trying to figure out a way to help his clients with depression and began to do experiments on these concepts. His experiments failed, but only in the way he expected. If he would not have failed, then CBT would not have been born. He continued working to help alleviate the depression in his clients and he found that this population of people would have negative thoughts appear randomly. He noticed that if a situation went badly for that patient that negative thoughts about themselves would appear in their minds. Beck called these "automatic thoughts" and that they were usually negative thoughts about the "client, the world, and/or the future" (Institute, 2019). When he realized this, he began to analyze these negative thoughts with the clients and show that they were irrational cognitions that could be changed with positive thinking. He named this new theory, Cognitive- Behavior Therapy.

CBT, as stated earlier, is used to transform negative, irrational thoughts into positive thinking to help clients. This is not all its used for. Exposure therapy and trauma-focused CBT are forms of CBT. Exposure therapy is used with anxiety disorders and phobias to help the

person get rid of their fears (Psychology, 2017). Social workers and clinicians that use CBT create steps and future goals for this person. Let's say there is a woman who is scared to drive a car because she saw a friend die in a car accident. This would be an example of trauma-focused CBT mixed with exposure therapy. Obviously, one wouldn't want to recreate the car accident, so the client would start at the smallest step that they feel comfortable with. They could be fine being near cars, so that's where they would start. One would get them to, hopefully, go from being near cars to getting in one to accomplishing the final step…driving.

CBT lets the client become the therapist (Institute, 2019). Cognitive-Behavior Therapy is not like other talking therapies. The client is in full control of their progress. The client works with the therapist to create their treatment plan. They also have homework that they do in between each session. CBT is designed for the client to discover their own power in transforming the negative cognitions that affect them. If the client isn't willing to do the work, then no progress will be made.

Just as there are pros and cons to everything in life, so there is in cognitive-behavior therapy. CBT does not take as many sessions to complete, if the client is doing their homework and working with their coping skills (Clinic, 2019). On the other hand, this does take a lot of time outside of sessions. Formerly stated, clients have homework that they have to do. Doing the sessions, outside homework, and just everyday coping/transforming any irrational thoughts into positive ones can take up a lot of time in a busy person's life. Let's go back to the woman with a fear of driving. Yes, it's great that she got over her fear of driving and her CBT therapy was a success, but there were also moments of increased anxiety and being uncomfortable (Clinic, 2019). One would like being uncomfortable in these situations. Now, obviously, the client would hate this, especially in anxiety and panic disorder cases, but social workers and clinicians use this

as an opportunity to teach the client that they are alright and the thoughts they are having of dying are not rational, but normal bodily reactions and that they are alright.

The topic of cognitive-behavior therapy and its usefulness in social work is divided between scholars. There are some scholars that believe CBT does not work for clients that have complex mental health disorders or that come from diverse cultural backgrounds (Rasmussen, 2018). According to Dr. Rasmussen's examination of CBT, he thought that based on trials and who was included/excluded in these trials, that there wasn't much evidence on CBT and minority groups (Rasmussen, 2018). Throughout his paper, he talks about how it should not be placed on a pedestal above other therapies when there is little evidence to show that it helps non-Western populations, but he also realizes that cognitive-behavior therapy has helped many individuals overcome their mental illnesses and live normal, everyday lives.

On the other side of the divide are social workers that believe that CBT coincides with the social work values found in the NASW's Code of Ethics. Social workers do everything for the client, as long as it helps them succeed in their treatment. In a study by Dr. Gonzalez-Prendes and Mrs. Brisebois, they asserted that CBT works with the social worker's values (Gonzalez-Prendes & Brisebois, 2012). CBT is an individual based treatment therapy. As social workers, they meet each client as an individual. The client is not based on their ethnicity, social status, race, age, gender, sexual orientation, etc. The client is seen as a person and their needs are individually met (Gonzalez- Prendes & Brisebois, 2012). Cognitive-Behavior Therapy is formulated to each individual and their own needs; what one person needs in therapy is not going to work for another individual and vice-versa.

How does this affect social work in the future? In one's own opinion, one would say that CBT will have positive implications on social work. More research is coming out on cognitive-

behavior therapy working with other mental illnesses. TF-CBT, which is trauma focused, is one of these researches. There was a trial study in 2015 that used TF-CBT for children with PTSD vs. normal PTSD treatment. The authors talked about how trauma-focused CBT was useful in PTSD cases (Dalgleish, 2015). Think back to the woman and her fear of driving. She witnessed a very traumatic moment and her therapy was trauma-focused. Her CBT would've been focused on her thoughts related to the car accident and helping her overcome those thoughts and being able to drive again. Cognitive-Behavior Therapy aligns with social work values because it focuses on the individual as a person and meets their individual needs, which is what social workers do. Dr. Rasmussen may not believe that CBT should be a top choice therapy, but one would believe that it should be used whenever possible. With more research on how it affects more complex mental illnesses and how it works with people of minorities and culturally diverse backgrounds, one would think that Cognitive-Behavior Therapy can have an increase in success rates and give more people the tools to help them transform their negative thoughts into positive ones in everyday life.

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