



On the Application of Cognitive Behavioral Therapy in Treating Foreign Language Listening Anxiety

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Abstract

Cognitive behavioral therapy (CBT) is a set of treatments that focus on altering thoughts, sensations, emotions and behaviors by addressing identified maintenance mechanisms such as distorted thinking or avoidance. The aim of this study was to assess whether the use of CBT techniques in reducing foreign language listening anxiety is an acceptable intervention, and provide a description of many of the basic techniques used in CBT. These included: psychoeducation, relaxation exercises, exposure and cognitive restructuring. A feasibility study of a brief CBT intervention following training was conducted. Qualitative analysis was carried out on participant feedback from semi-structured interviews. The current article provided an interdisciplinary way for foreign language teachers to help college students reduce foreign language listening anxiety and improve learning achievements.

Key words: Foreign language listening anxiety; Cognitive behavioral therapy; Exposure

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INTRODUCTION

The emergence of cognitive behavioral therapies (CBT) since the early 1960s sparked a period, termed the

“cognitive revolution” (Dobson & Dozois, 2010), a shift in approach that aimed to restructure one’s thoughts while simultaneously perpetuating desirable behavior. The foundation of CBT is embedded in the notion that one may elicit cognitive activity mediating behavioral and affective change. The CBT model conceptualizes situations, thoughts, feelings, and behavior as being connected. It interrupts the cycle of automatic thoughts (evoked by a stimulus), replacing them with alternative thinking strategies that bring about behavior change. Consequently, the emphasis on cognitive mechanisms to create a change in behavior is what differentiates this from behavior therapy. As such, CBT refers to the interventions based on the basic premise that emotional disorders are maintained by cognitive factors, and that psychological treatment leads to changes in these factors through cognitive restructuring and behavioral techniques (e.g., exposure, behavioral experiments relaxation training, social skills training) (Hoffman & Smits, 2008). CBT for anxiety disorders focuses on addressing negative automatic appraisals of anxiety-provoking or potentially distressing situations (including modifying negative reactions to the experience of anxiety itself) and countering maladaptive patterns of behavioral avoidance. This essay tries to focus on the application of CBT in treating language anxiety, including a few techniques: relaxation exercises, exposure, psychoeducation and cognitive restructuring.

1. LITERATURE REVIEW

1.1 Studies of Foreign Language Listening Anxiety

MacIntyre and Gardner (1994b) defined language anxiety as the feeling of tension and apprehension specifically connected with the second language contexts, including speaking, listening and learning. A more detailed description of language anxiety was provided by Horwitz

et al. (1986). They regarded communication apprehension, test anxiety, and fear of negative evaluation as the conceptual building blocks for the description of language anxiety.

In the case of Foreign Language (FL) learning, listening anxiety (LA) is related to “the way listeners select and interpret information that comes from the auditory and/or visual cues” (Piechurska-Kuciel, 2014). Anxiety may arise when learners find the listening comprehension task too difficult and also arise from the learner’s poor strategy usage, and the anticipation of not being able to cope with the task successfully, leading to fear of failure. The fact that learners may worry about both being unable to understand the message and committing mistakes in listening tasks, is emphasized by MacIntyre (1995). It can be assumed that the worry is boosted by the fact that the mistake is made in the presence of classmates, who might be perceived by the anxious students to be better FL learners than they are.

Next to the factual low level of listening comprehension, it is also, if not more importantly, the perceptions and beliefs of FL students related to this skill that may boost listening anxiety. On the basis of a thorough review of research on LA, Young (1991) contends that “personal and interpersonal anxieties” constitute the most frequently observed sources of anxiety. Among them are self-perceptions, such as self-esteem and self-assessment. Analyzing the results of research conducted by Hembree (1988), Young (1991) concludes that learners “with a self-perceived low ability level in a foreign or second language are the likeliest candidates for language anxiety”. Similarly, a strong link between self-esteem and the level of language anxiety is emphasized by Krashen (1981), who states the following: “...the more I think about self-esteem, the more impressed I am with its impact. This is what causes anxiety in a lot of people”. Analogous conclusions were drawn by Bailey (1983) on the basis of diary studies. The researcher observed that highly anxious participants perceived themselves as less skillful FL learners than their classmates. Gardner and MacIntyre (1993) reported a significant correlation between students’ self-ratings and their level of LA, while Onwuegbuzie et al. (1999) concluded that highly anxious students have “negative perceptions of their scholastic competence ... or negative perception of their self-worth”. Finally, a moderate correlation between students’ self-assessment of all FL skills and their LA level was found by Piechurska-Kuciel (2008).

1.2 Studies of Cognitive Behavioral Therapy

A variety of approaches to therapy are generally considered to fall within the broader domain of cognitive behavioral therapy (Dobson and Dozios, 2001). These approaches share three assumptions:

- Cognition affects behavior
 - Cognition can be monitored and altered
 - Behavior change is mediated by cognitive change
- CBT always involves cognitive mediation of behavior as the fundamental core of treatment.

Cognitive behavioral therapies can be grouped under three broad categories:

- Coping skills methods
- Problem-solving methods
- Cognitive restructuring methods

It is generally accepted that the different categories of therapy are best suited for different kinds of presenting problems. For example, the coping skills therapies are best applied to clients that are reacting to problems or situations occurring outside of themselves. These approaches focus on changing cognitions that serve to exacerbate the consequences of a negative event and on improving cognitive and behavioral approaches to coping with that event. Cognitive restructuring methods are best applied to problems emerging from within the psyche and thus require a more comprehensive and multilevel approach to cognitive change.

Distressing thoughts and emotions are common among psychiatric disorders characterized by negative affect, including depression, anxiety disorders, eating disorders, and psychosis (Yoval, Mor, & Shkarov, 2014). Specifically, CBT has been applied to an array of presenting concerns experienced by children and adolescents, including hyperactivity, aggression, and disruptive behaviors. A few CBT measurements of success include: academic outcomes, increases in social reasoning abilities, improved peer relationships, and maintenance of these changes. For children and adolescents, CBT focuses on schema development and the cognitive processes of automatic thoughts (Christner, Stewart, & Freeman, 2007).

In addition to the ability to teach reasoning and thinking of alternative ways to solve a problem, CBT includes behavioral and physiological components (such as deep breathing, guided imagery, and progressive muscle relaxation). Programs can be implemented to address the cognitive, behavioral, and physiological components of psychological dysfunction when working with adolescents struggling from internalizing (e.g., anxiety and depression) symptomology (Fisak, Richard, & Mann, 2011). Indeed, mindfulness techniques have gained popularity in recent years and are being applied (often very successfully) to a variety of therapeutic treatment plans (Brown, Marquis, & Guiffreda, 2013). However, the existing literature regarding the application of CBT on treating foreign language listening anxiety is sparse, resulting in gaps in knowledge about generalizability and effectiveness of such treatments for Chinese foreign language learners.

2. SURVEY ON CHINESE STUDENTS' FOREIGN LANGUAGE LISTENING ANXIETY

The level of the participants' listening anxiety was diagnosed by applying a listening anxiety 20-item questionnaire, i.e. the Foreign Language Listening Anxiety Scale (FLLAS) taken from Elkhafaifi (2005). The instrument is an adaptation of a battery designed originally by Saito et al. (1999) to measure reading anxiety. The changes introduced by Elkhafaifi consisted mainly in substituting the word "reading" with "listening". The testees' task was to mark on a five-point Likert scale the extent to which they agreed/disagreed with statements referring to feelings experienced when trying to understand spoken English, such as "I get upset when I'm not sure whether I understand what I'm hearing in English", "When I'm listening to English, I get so confused I can't remember what I've heard", or "I don't mind listening to English by myself but I feel very uncomfortable when I have to listen to English in a group". The questionnaire was translated into Chinese. The participants completed it during one of their English classes in the presence of the author of this paper, in case any problems with understanding the statements appeared. The subjects could achieve from 20 to 100 points, where a high score corresponded to a high level of listening anxiety and a low score to a low level of listening anxiety.

Semi-structured interviews were carried out individually with six representatives of learners classified with the use of the FLLAS as either high listening anxiety students (those who scored over 1 SD above the mean) or low listening anxiety students (those who scored over 1 SD below the mean). The conversations allowed us to triangulate the quantitative data and to provide a deeper insight into the feelings experienced by learners.

The results show that the worry and tension accompanying listening tasks and situations may result from the fact that the skill is difficult by nature. What makes it difficult is the dynamic tempo, the continuity of speech (i.e. lack of audible pauses between lexical items that would help identify them), the dependence on the flow of spoken language, and the need to decode massive amounts of input of various types (phonological, lexical, syntactic) on-line. Additionally, it is not indifferent to the FL listener that, unlike in real life contexts, in the case of the FL classroom listening tasks, no visual clues are provided by the surroundings hints offered in natural settings by the interlocutor(s), such as body language and gestures.

3. CBT INTERVENTIONS FOR FOREIGN LANGUAGE LISTENING ANXIETY

CBT is a structured form of therapy guided by the cognitive model. The cognitive model proposes that

dysfunctional thinking and unrealistic cognitive appraisals of certain life events can negatively influence feelings and behavior and that this process is reciprocal, generative of further cognitive impairment, and common to all psychological problems.

CBT for anxiety focuses on teaching skills to help patients disengage from the cycle of worry and develop more realistic, less catastrophic assessments of uncertain outcomes. The patient is encouraged to keep a "worry record" on which they record triggers for worry, maximum level of anxiety about the worry produce, anxious worry related thoughts, and anxious behaviors. Worry records help the patient to identify specific triggers and/or patterns in their worrying, such as increased worry at certain times in the day or worry triggered by certain interactions or situations. After the patient identified maladaptive automatic appraisals and other dysfunctional thinking patterns, several CBT approaches can be applied to reduce anxiety.

3.1 Psychoeducation

Psychoeducation about the cycle of anxiety is considered a crucial initial intervention for correcting the patient's experience of distress. It is important that patients understand the functional role anxiety and other emotions play in our lives and why it would not be helpful to eliminate these experiences entirely. For example, anxiety functions to motivate us to prepare for something in the future, like preparing for an exam or a presentation at work. Emotions like fear and anger are also important, allowing us to defend ourselves against harm. Anxiety and other emotions become problematic when they are experienced as something aversive or when they are disproportionately intense given the current context. Thus, a primary goal of treatment is learning to identify when these emotions are useful and what the patient can do differently in order for them to become more tolerable. The CBT model of emotions offers a framework for understanding how anxiety is modulated based on how our cognitions (perceptions of events), behaviors (avoidance, escape, reassurance seeking), and physical reactions (heart racing, shortness of breath) are associated. Patients often attribute the causes of their emotional experience (fear and anxiety) to the situation. However, patients can learn that specific ways in which they respond to their triggered emotions have an effect on their intensity. Therefore, a primary goal of treatment is the identification and alteration of these maladaptive patterns of responding.

Patients are also taught how the cycle of anxiety is maintained, developing out of a learned response to their respective stressors through a pattern of avoidance and escape behaviors. These behaviors function effectively to relieve distress in the short run but maintain the problem in the long run because the anxiety and fear associated with the situation or experience remains.

Without any opportunity to experience the ability to cope with the situation or experience, the aversiveness of the experience is reinforced and perpetuated. Thus, the cycle of avoidance is reinforced in the short term through a temporary reduction in anxiety and maintained over the long term by perpetuating the appraisal of the situation or experience as threatening.

Psychoeducation also involves teaching the patient the importance of self-monitoring. Through self-monitoring, the patient increases his awareness of maladaptive coping strategies and can begin to practice and consolidate skills learned through treatment. Patients are encouraged to begin self-monitoring by recording triggers for anxiety; thoughts, feelings, and behaviors they experience in response to the trigger; and the consequences of this response, both short term and long term. Subjective self-monitoring of symptom complaints also facilitates the patient's awareness of symptoms targeted for change. Patients with low emotional awareness and/or emotional intolerance can learn more about their emotional experience by engaging in daily tracking of moods, including intensity ratings, for indications of elevations in anxiety, fear, panic, anger, guilt, shame, sadness, depression, joy, pleasure, calm, etc. Providing patients with a handout of labels used to name specific emotions can be especially useful for patients who lack the awareness of shifts in affect and/or a vocabulary for describing their emotional experience.

Finally, the importance of engaging in self-monitoring through specific "homework" assignments throughout treatment is emphasized as a crucial tool for consolidating skills. Weekly homework assignments developed collaboratively between therapist and patient can serve as useful means of gauging the patient's engagement in treatment and progress toward skill-building efforts.

3.2 Relaxation Exercises

Some CBT approaches to anxiety emphasize relaxation techniques, such as progressive muscle relaxation, as a way to counter the physical tension that is both triggered and fueled by anxiety and worry. In this approach, learning to relax on cue functions as a way to interrupt the cycle of worry. Relaxation techniques are taught to a level of mastery under low stress conditions before being applied as a stress management technique in order to minimize risks of misattributing relaxation training with distress. Other more recent approaches emphasize the use of present-focused mindful awareness as a tool for disengaging from worry. In this technique, patients are taught skills for noticing and observing their experiences in a nonjudgmental, accepting way. Focusing on the present moment allows the patient to disengage from the cycle of negative, future-oriented worrying, allowing for more corrective information about the current situation to be noticed and recognized (e.g., that he/she is able

to cope in this moment). For example, after practicing mindfulness exercises such as breath awareness or noticing the sights and sounds, Wang was able to apply this skill in order to shift his attention from his worry to the present moment. In this way, he was able to allow the realization that he was currently doing quite well at his English listening learning and was liked by his teacher to enter his mind.

3.3 Exposure

Exposure work begins with the construction of a fear and avoidance hierarchy. The therapist works collaboratively with the patient to create a list of the patient's feared situations and experiences, placing the most feared situation at the top of the list and working down the list with less and less intense experiences. It is important that the patient achieves a sense of mastery at the start of exposure work, in order to gain confidence in his ability to successfully approach and cope with distressing or uncomfortable experience. Thus, when designing exposure exercises, the therapist should start at the bottom of the hierarchy and work up the hierarchy week by week. Exposure exercises should be done in-session first, under the guidance of the therapist. In order to maximize the potential for new learning to take place, it is important that the patient be fully engaged in the exercises, allowing himself/herself to experience his/her emotions without attempting to dampen them or avoid them. Thus, the therapist should be mindful of subtle attempts by the patient to avoid experiencing anxiety, such as averting eye contact, fidgeting or "bracing" himself/herself, or rushing through an exposure.

Exposures in CBT for anxiety include imagining the worst possible outcomes in vivid detail (imaginal exposures) and countering maladaptive behaviors in which the patient engages in response to worry (e.g., checking and rechecking work for mistakes). In imaginal exposures, the patient is asked to first identify the worst-case scenario related to a worry topic (e.g., failing in an exam). The patient is then asked to describe in vivid detail the image of that feared or anxiety-provoking scenario taking place, including what happens next.

Using cued relaxation or mindfulness strategies, the patient is then asked to observe and challenge assumptions and beliefs inherent in the imagined scenario. The therapist instructs the patient to schedule the exposure exercise to occur repeatedly at a designated time and dedicated space (e.g., scheduled worry time in a worry chair). This process is repeated until the image becomes less distressing over repeated trials. Once habituation to one worry topic is achieved, the same procedure can be applied to a different worry domain until all the areas of worry are effectively challenged. After repeated exposure to these distressing images, the patient begins to distinguish the image from reality and begins to see ways in which he/she might cope should

the catastrophic scenario take place, thereby weakening the distress associated with the worry thought.

3.4 Cognitive Restructuring

In some forms of CBT, cognitive restructuring is the most essential and theoretically the main mechanism of change. The general principle behind cognitive restructuring is examining a specific incident and the thoughts that occurred during that incident (sometimes elicited by the thought record). The patient is asked to recall in detail the context of the situation that led to an intensification of his or her emotional experience (e.g., "I felt depressed and anxious when I went to school"). This is to facilitate elicitation of "hot" cognition: Thoughts that are emotionally laden. Then, the patient is asked to describe what thoughts came to mind within that context (e.g., "I thought I will never pass the exam"). The thoughts are then evaluated for their basis in logic and reality, with the goal of helping the patient reevaluate distorted thoughts in a way that is more accurate, and likely to decrease the negative emotional reaction that they had within the situation (e.g., "How many times have you failed before? What is the worst thing that would happen if you failed?" leading to answers like "Well, I got an 80 once when I was sick," with the therapist then asking, "So what is the likelihood that you will get a 60?" and the patient saying, "Yeah, I guess I exaggerate a lot when I feel bad. I really will do ok on the exam"). There are a number of variations of how cognitive restructuring is done. The most traditional method is via the thought record.

In some forms of CBT, part of the evaluation process is labeling the type of cognitive distortion that characterizes the specific thought such as all or none thinking, disqualifying the positive, mental filtering, jumping to conclusions, catastrophizing, emotional reasoning, should statements, and personalization. Others skip the labeling step and go directly to work with the patient in developing rational responses to the thoughts. After the development of realistic, rational responses, the patient is asked to reevaluate the intensity of the emotional experience in order to determine whether the changes in appraisal/thinking impacted the patient emotionally. In this project, the cognitive restructuring is conducted during an exposure. More active, immediate development of rational responses is preferred.

CONCLUSION

CBT for listening anxiety is a collaborative, participant-centered approach to treatment. It is also a challenging approach to treatment, in that it requires active and effortful participation by participants. For those participants who are able and motivated to engage in CBT, it is a highly effective approach. There are many individual CBT treatment protocols available

for listening anxiety. However, key principles of CBT, including the modification of maladaptive automatic appraisals and the countering of behavioral avoidance through exposure, can be found across these available treatments. The ultimate goal of CBT for listening anxiety is to help participants learn new ways of relating to their anxiety and other distressing emotions, so that these experiences no longer limit their ability to comprehend English listening.

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