

COGNITIVE CONCEPTUALIZATION

A cognitive conceptualization provides the framework for the therapist's understanding of a patient. He asks himself the following questions to initiate the process of formulating a case:

- What is the patient's diagnosis?
- What are her current problems, how did these problems develop and how are they maintained?
- What dysfunctional thoughts and beliefs are associated with the problems; what reactions (emotional, physiological, and behavioral) are associated with her thinking?

Then the therapist hypothesizes how it is that the patient developed this particular psychological disorder:

- What early learning and experience (and perhaps genetic predispositions) contribute to her problems today?
- What are her underlying beliefs (including attitudes, expectations, and rules) and thoughts?
- How was she coped with her dysfunctional beliefs? What cognitive, affective, and behavioral mechanisms, positive and negative, has she developed to cope with her dysfunctional beliefs? How did (and does) she view herself, others, her personal world, her future?
- What stressors contributed to her psychological problems or interfere with her ability to solve these problems?

The therapist begins to construct a cognitive conceptualization during his first contact with a patient and continues to refine his

conceptualization until their last session. This organic, evolving formulation helps him to plan for efficient and effective therapy (Persons, 1989). In this chapter, the cognitive model, the theoretical basis of cognitive therapy, is described. The relationship of thoughts and beliefs is then discussed and the case example of Sally, used throughout this book, is presented.

THE COGNITIVE MODEL

Cognitive therapy is based on the *cognitive model*, which hypothesizes that people's emotions and behaviors are influenced by their perception of events. It is not a situation in and of itself that determines what people feel but rather the way in which they *construe* a situation (Beck, 1964; Ellis, 1962). Imagine, for example, a situation in which several people are reading a basic text on cognitive therapy. They have quite different emotional responses to this situation based on what is going through their minds as they read.

Reader A thinks, "Hey, this really makes sense. Finally, a book that will really teach me to be a good therapist!" Reader A feels mildly excited.

Reader B, on the other hand, thinks, "this stuff is too simplistic. It will never work," and feels disappointed.

Reader C has the following thoughts: "This book isn't what I expected. What a waste of money." Reader C is disgusted.

Reader D thinks, "I really need to learn all this. What if I don't understand it? What if I never get good at it?" and feels anxious.

Reader E has different thoughts: "This is just too hard. I'm so dumb. I'll never master this. I'll never make it as therapist." Reader E feels sad.

So the way people feel is associated with the way in which they interpret and think about a situation. The situation itself does not directly determine how they feel; their emotional response is mediated by their perception of the situation. The cognitive therapist is particularly interested in the level of thinking that operates simultaneously with the more obvious, surface level of thinking.

For example, while you are reading this text, you may notice a number of levels in your thinking. Part of your mind is focusing on the information in the text; that is, you are trying to understand and integrate some factual information. At another level, however, you may be having some quick, evaluative thoughts. These thoughts are called *automatic thoughts* and are not the result of deliberation or reasoning. Rather, these thoughts seem to spring up automatically; they are often quite rapid and

brief. You may be barely aware of these thoughts; you are far more likely to be aware of the emotion that follows. As a result, you most likely uncritically accept your automatic thoughts as true. You can learn, however, to identify your automatic thoughts by attending to your shifts in affect. When you notice that you are feeling dysphoric, ask yourself: *What was going through my mind just then?*

Having identified your automatic thoughts, you can, and probably already do to some extent, evaluate the validity of your thoughts. If you find your interpretation is erroneous and you correct it, you probably discover that your mood improves. In cognitive terms, when dysfunctional thoughts are subjected to rational reflection, one's emotions generally change. Chapter 8 offers specific guidelines on how to evaluate automatic thoughts.

But where do automatic thoughts spring from? What makes one person construe a situation differently from another person? Why may the same person interpret an identical event differently at one time than at another? The answer has to do with more enduring cognitive phenomena: beliefs.

BELIEFS

Beginning in childhood, people develop certain beliefs about themselves, other people, and their worlds. Their most central or *core beliefs* are understandings that are so fundamental and deep that they often do not articulate them, even to themselves. These ideas are regarded by the person as absolute truths, just the way things "are." For example, Reader E, who thought he was too dumb to master this text, might have the core belief, "I'm incompetent." This belief may operate only when he is in a depressed state or it may be activated much of the time. When this core belief is activated, Reader E interprets situations through the lens of this belief, even though the interpretation may, on a rational basis, be patently untrue. Reader E, however, tends to focus selectively on information that confirms the core belief, disregarding or discounting information that is to the contrary. In this way he maintains the belief even though it is inaccurate and dysfunctional.

For example, Reader E did not consider that other intelligent, competent people might not fully understand the material in their first reading. Nor did he entertain the possibility that the author had not presented the material well. He did not recognize that his difficulty in comprehension could be due to a lack of concentration rather than a lack of brain power. He forgot that he often had difficulty initially when presented with a body of new information but later had an excellent track record of mastery. Because his incompetence belief was activated, he automatically interpreted the situation in a highly negative, self-critical way.

Core beliefs are the most fundamental level of belief; they are global, rigid, and overgeneralized. *Automatic thoughts*, the actual words or images that go through a person's mind, are situation specific and may be considered the most superficial level of cognition. The following section describes the class of *intermediate beliefs* that exists between the two.

ATTITUDES, RULES, AND ASSUMPTIONS

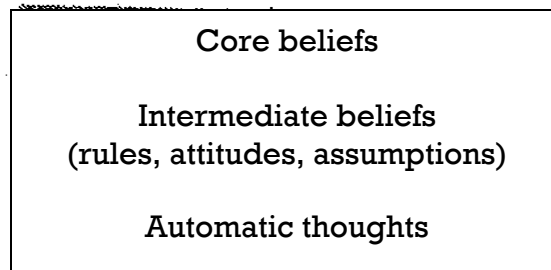
Core beliefs influence the development of an intermediate class of beliefs which consists of (often unarticulated) attitudes, rules, and assumptions. Reader E, for example, had the following intermediate beliefs:

Attitude: "It's terrible to be incompetent."

Rules/expectations: "I must work as hard as I can all the time."

Assumption: "If I work as hard as I can, I may be able to do some things that other people can do easily."

These beliefs influence his view of a situation, which in turn influences how he thinks, feels, and behaves. The relationship of these intermediate beliefs to core beliefs and automatic thoughts is depicted below:



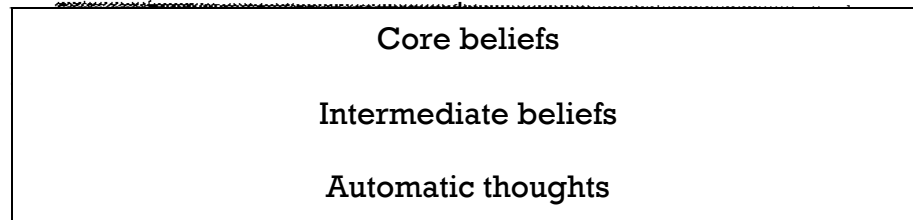
How do the core beliefs and intermediate beliefs arise? People try to make sense of their environment from their early developmental stages. They need to organize their experience in a coherent way in order to function adaptively (Rosen, 1988). Their interactions with the world and other people lead to certain understandings or learnings, their beliefs, which may vary in their accuracy and functionality. What is of particular significance to the cognitive therapist is that beliefs that are dysfunctional can be unlearned and new beliefs that are more reality based and functional can be developed and learned through therapy.

The usual course of treatment in cognitive therapy involves an initial emphasis on automatic thoughts, those cognitions closest to conscious awareness. The therapist teaches the patient to identify, evaluate, and modify her thoughts in order to produce symptom relief. Then the beliefs that underlie the dysfunctional thoughts and cut across many

situations become the focus of treatment. Relevant intermediate-level beliefs and core beliefs are evaluated in various ways and subsequently modified so that patients' conclusions about and perceptions of events change. This deeper modification of more fundamental beliefs makes patients less likely to relapse in the future (Evans et al., 1992; Hollon, DeRubeis, & Seligman, 1992).

RELATIONSHIP OF BEHAVIOR TO AUTOMATIC THOUGHTS

The cognitive model, as it has been explained to this point, can be illustrated as follows:



In a specific situation, one's underlying beliefs influence one's perception, which is expressed by situation-specific automatic thoughts. These thoughts, in turn, influence one's emotions.

Proceeding one step further, automatic thoughts also influence behavior and often lead to a physiological response, as illustrated in Figure 2.1.

The reader who has the thoughts, "This is too hard. I'll never understand this," feels sad, experiences a sense of heaviness in his abdomen, and closes the book. Of course, had he been able to *evaluate* his thinking, his emotions, physiology, and behavior may have been positively affected. For example, he may have responded to his thoughts by saying, "Wait a minute. This may be hard, but it's not necessarily impossible. I've been able to understand this type of book before. If I keep at it, I'll probably understand it better." Had he responded in such a way, he may have reduced his sadness and kept reading.

To summarize, this reader felt sad because of his thoughts in a particular situation. Why did he have these thoughts when another reader did not? Unarticulated core beliefs about his incompetence influenced his perception of the situation.

As explained in the beginning of this chapter, it is essential for the therapist to learn to conceptualize patients' difficulties in cognitive terms in order to determine how to proceed in therapy—when to work on a specific goal, automatic thought, belief, or behavior; what techniques to choose; and how to improve the therapeutic relations. The basic

to reach that destination; for example, by main highways or back roads. Sometimes detours change the original plan. As the therapist becomes experienced and better at conceptualization, he fills in the relevant details in the road map and his efficiency and effectiveness improve. At the beginning, however, it is reasonable to assume that he may not accomplish therapy in the most effective way. A correct cognitive conceptualization aids him in determining what the main highways are and how best to travel.

Conceptualization begins at the first contact with a patient and is refined at every subsequent contact. The therapist hypothesizes about the patient, based on the data the patient presents. Hypotheses are either confirmed, disconfirmed, or modified as new data are presented. The conceptualization, therefore, is fluid. At strategic points, the therapist directly checks his hypotheses and formulation with the patient. Generally, if the conceptualization is on target, the patient confirms that it "feels right"—she agrees that the picture the therapist presents truly resonates with her.

CASE EXAMPLE

Sally is an 18-year-old college freshman who sought therapy for persistent sadness, anxiety, and loneliness. Her intake evaluator determined that she suffered from a major depressive episode of moderate severity which had begun during the first month of school, 4 months prior to her entry into therapy.

Most questions that the intake evaluator asked Sally were fairly standard, but several were added so the evaluator and therapist could begin to form a cognitive conceptualization. For example, the evaluator asked Sally when she generally felt the worst—which situations and/or times of day. Sally replied that she felt worst at bedtime, as she lay in bed, trying to fall asleep. The evaluator then asked the key question: *"What goes through your mind at these times? What specific thoughts and/or images do you have?"*

Thus, right from the beginning, a sample of important automatic thoughts is obtained. Sally replied that she has thoughts such as the following: "I'll never be able to finish my term paper." "I'll probably flunk out of here." "I'll never be able to make anything of myself." Sally also reported an image that flashed through her mind. She saw herself, suitcase in hand, trudging aimlessly down the street, looking quite downtrodden, directionless, and desperate. During the course of therapy, Sally's therapist rounds out his conceptualization. He organizes his thinking through the use of a Case Summary Worksheet (Appendix A) and a Case Conceptualization Diagram (see Chapter 10; Figure 10.2).

ball, for example. So Sally also developed a counterbalancing positive belief that she was competent in some respects.

Sally's other core beliefs about her world and about other people were, for the most part, positive and functional. She generally believed that other people were friendly, trustworthy, and accepting. And she perceived her world as being relatively safe, stable, and predictable.

Again, Sally's core beliefs about herself, others, and her world were her most basic beliefs, which she had never really articulated until she entered therapy. As a young adult, her more positive core beliefs were dominant until she became depressed, and then her highly negative core beliefs became activated.

Sally's Attitudes, Rules, and Assumptions

Somewhat more amenable to modification than her core beliefs were Sally's intermediate beliefs. These attitudes, rules, and assumptions developed in the same way as core beliefs, as Sally tried to make sense of her world, of others, and of herself. Mostly through interactions with her family and significant others, she developed the following attitudes and rules:

"I should be great at everything I try."

"I should always do my best."

"It's terrible to waste your potential."

As was the case with her core beliefs, Sally had not fully articulated these intermediate beliefs. But the beliefs nevertheless influenced her thinking and guided her behavior. In high school, for example, she did not try out for the school newspaper (though it interested her) because she assumed she could not write well enough. She felt both anxious before exams, thinking that she might not do well, and guilty, thinking that she should have studied more.

When her more positive core beliefs predominated, however, she saw herself in a more positive light, although she never completely believed that she was competent and not inferior. She developed the assumption: "If I work hard, I can overcome my shortcomings and do well in school." When she became depressed, however, Sally did not really believe this assumption any longer and substituted the belief, "Because of my deficiencies, I'll never amount to anything."

Sally's Strategies

The idea of being inadequate had always been quite painful to Sally, and she developed certain behavioral strategies to shield herself from this

in. As might be gleaned from her intermediate beliefs, Sally worked hard at school and at sports. She overprepared her assignments and studied quite hard for tests. She also became hypervigilant for signs of inadequacy and redoubled her efforts if she failed to master something at school. She rarely asked others for help for fear they would recognize her inadequacy.

Sally's Automatic Thoughts

While Sally did not articulate these core beliefs and intermediate beliefs (until therapy), she was at least somewhat aware of her automatic thoughts in specific situations. In high school, for example (during which time she was not depressed), she tried out for the girls' softball and hockey teams. She made the softball team and thought, "That's great. I'll get Dad to practice batting with me." When she failed to make the hockey team, she was disappointed but not particularly self-critical.

In college, however, Sally became depressed during her freshman year. Later, when she considered playing an informal baseball game with students in her dorm, her depression influenced her thinking: "I'm no good. I probably won't even be able to hit the ball." Similarly, when she got a "C" on an English literature examination, she thought, "I'm so stupid. I'll probably fail the course. I'll never be able to make it through college."

To summarize, in her nondepressed high school years, Sally's more positive core beliefs were activated and she generally had relatively more positive (and more realistic) thoughts. In her freshman year in college, however, her negative beliefs predominated during her depression, which led her to interpret situations quite negatively and to have predominantly negative (and unrealistic) thoughts. These distorted thoughts also led her to *behave* in self-defeating ways, thereby giving her more ammunition with which to put herself down.

Sequence Leading to Sally's Depression

How is it that Sally became depressed? Certainly, her negative beliefs helped predispose her to depression. When she got to college, she had several experiences which she interpreted in a highly negative fashion. One such experience occurred the first week. She had a conversation with other freshmen in her dorm who were relating the number of advanced placement courses and exams they had taken which exempted them from several basic freshman courses. Sally, who had no advanced placement credits, began to think how superior these students were to her. In her economics class, her professor outlined the course requirements and Sally immediately thought, "I won't be able to do the research paper." She had difficulty understanding the first chapter in her statistics

book and she thought, "If I can't even understand Chapter 1, how will I ever make it through the course?"

So Sally's beliefs made her vulnerable to interpreting events in a negative way. She did not question her thoughts but rather accepted them uncritically. The thoughts and beliefs themselves did not cause the depression. However, once the depression set in, these negative cognitions strongly influenced her mood. Her depression undoubtedly was caused by a variety of biological and psychological factors.

For example, as the weeks went on, Sally began to have more and more negative thoughts about herself and began to feel more and more discouraged and sad. She began to spend an inordinate amount of time studying, although she did not accomplish a great deal because of decreased concentration. She continued to be highly self-critical and even had negative thoughts about her depressive symptoms: "What's wrong with me? I shouldn't feel this way. Why am I so down? I'm just hopeless." She withdrew somewhat from new friends at school and stopped calling her old friends for support. She discontinued running and swimming and other activities that had previously provided her with a sense of accomplishment. Thus, she experienced a paucity of positive inputs. Eventually, her appetite decreased, her sleep became disturbed, and she became enervated and listless. Sally may indeed have had a genetic predisposition for depression; however, her perception of and behavior in the circumstances at the time undoubtedly facilitated the expression of a biological and psychological vulnerability to depression.

SUMMARY

Conceptualizing a patient in cognitive terms is crucial in order to determine the most efficient and effective course of treatment. It also aids in developing empathy, an ingredient that is critical in establishing a good working relationship with the patient. In general, the questions to ask when conceptualizing a patient are:

- How is it that the patient came to develop this disorder?
- What were significant life events, experiences, and interactions?
- What are her most basic beliefs about herself, her world, and others?
- What are her assumptions, expectations, rules, and attitudes (intermediate beliefs)?
- What strategies has the patient used throughout life to cope with these negative beliefs?
- Which automatic thoughts, images, and behaviors help to maintain the disorder?

How did her developing beliefs interact with life situations to make the patient vulnerable to the disorder?

What is happening in the patient's life right now and how is the patient perceiving it?

Again, conceptualization begins at the first contact and is an ongoing process, always subject to modification as new data are uncovered and previous hypotheses are confirmed or rejected. The therapist bases his hypotheses on the data he has collected, using the most parsimonious explanation and refraining from interpretations and inferences not clearly based on actual data. The therapist checks out the conceptualization with the patient at strategic points to ensure that it is accurate as well as to help the patient understand herself and her difficulties. The ongoing process of conceptualization is emphasized throughout this book; Chapters 10 and 11 illustrate further how historical events shape a patient's understanding of herself and her world.