

INTRODUCTION

Cognitive therapy was developed by Aaron T. Beck at the University of Pennsylvania in the early 1960s as a structured, short-term, present-oriented psychotherapy for depression, directed toward solving current problems and modifying dysfunctional thinking and behavior (Beck, 1964). Since that time, Beck and others have successfully adapted this therapy to a surprisingly diverse set of psychiatric disorders and populations (see, e.g., Freeman & Dattilio, 1992; Freeman, Simon, Beutler, & Arkowitz, 1989; Scott, Williams, & Beck, 1989). These adaptations have changed the focus, technology, and length of treatment, but the theoretical assumptions themselves have remained constant. In nutshell, the *cognitive model* proposes that distorted or dysfunctional thinking (which influences the patient's mood and behavior) is common to all psychological disturbances. Realistic evaluation and modification of thinking produce an improvement in mood and behavior. Enduring improvement results from modification of the patient's underlying dysfunctional beliefs.

Various forms of cognitive-behavioral therapy have been developed by other major theorists, notably Albert Ellis's rational-emotive therapy (Ellis, 1962), Donald Meichenbaum's cognitive-behavioral modification (Meichenbaum, 1977), and Arnold Lazarus's multimodal therapy (Lazarus, 1976). Important contributions have been made by many others including Michael Mahoney (1991), and Vittorio Guidano and Giovanni Liotti (1983). Historical overviews of the field provide a rich description of how the different streams of cognitive therapy originated and grew (Arnkoff & Glass, 1992; Hollon & Beck, 1993).

Cognitive therapy as developed and refined by Aaron Beck is emphasized in this volume. It is unique in that it is a system of psychotherapy with a unified theory of personality and psychopathology supported by substantial empirical evidence. It has an operationalized

therapy with a wide range of applications, also supported by empirical data, which are readily derived from the theory.

Cognitive therapy has been extensively tested since the first outcome study was published in 1977 (Rush, Beck, Kovacs, & Hollon, 1977). Controlled studies have demonstrated its efficacy in the treatment of major depressive disorder (see Dobson, 1989, for a meta-analysis), generalized anxiety disorder (Butler, Fennell, Robson, & Gelder, 1991), panic disorder (Barlow, Craske, Cerny, & Klosko, 1989; Beck, Sokol, Clark, Berchick, & Wright, 1992; Clark, Salkovskis, Hackmann, Middleton, & Gelder, 1992), social phobia (Gelernter et al., 1991; Heimberg et al., 1990), substance abuse (Woody et al., 1983), eating disorders (Agras et al., 1992; Fairburn, Jones, Peveler, Hope, & Doll, 1991; Garner et al., 1993), couples problems (Baucom, Sayers, & Scher, 1990), and inpatient depression (Bowers, 1990; Miller, Norman, Keitner, Bishop, & Dow, 1989; Thase, Bowler, & Harden, 1991).

Cognitive therapy is currently being applied around the world as the sole treatment or as an adjunctive treatment for other disorders. A few examples are obsessive-compulsive disorder (Salkovskis & Kirk, 1989), posttraumatic stress disorder (Dancu & Foa, 1992; Parrott & Howes, 1991), personality disorders (Beck et al., 1990; Layden, Newman, Freeman, & Morse, 1993; Young, 1990), recurrent depression (R. DeRubeis, personal communication, October 1993), chronic pain (Miller, 1991; Turk, Meichenbaum, & Genest, 1983), hypochondriasis (Warwick & Salkovskis, 1989), and schizophrenia (Chadwick & Lowe, 1990; Kingdon & Turkington, 1994; Perris, Ingelson, & Johnson, 1993). Cognitive therapy for populations other than psychiatric patients is being studied as well: prison inmates, school children, medical patients with a wide variety of illnesses, among many others.

Persons, Burns, and Perloff (1988) have found that cognitive therapy is effective for patients with different levels of education, income, and background. It has been adapted for working with patients at all ages, from preschool (Knell, 1993) to the elderly (Casey & Grant, 1993; Thompson, Davies, Gallagher & Krantz, 1986). Although this book focuses exclusively on individual treatment, cognitive therapy has also been modified for group therapy (Beutler et al., 1987; Freeman, Schrodtt, Gilson, & Ludgate, 1993), couples problems (Baucom & Epstein, 1990; Dattilio & Padesky, 1990), and family therapy (Bedrosian & Bozicas, 1994; Epstein, Schlesinger, & Dryden, 1988).

With so many adaptations, how does cognitive therapy remain recognizable? In all forms of cognitive therapy that are derived from Beck's model, treatment is based on both a cognitive formulation of a specific disorder and its application to the conceptualization or understanding of the individual patient. The therapist seeks in a variety of ways to produce cognitive change—change in the patient's thinking and belief system—in order to bring about enduring emotional and behavioral change.

In order to describe the concepts and process of cognitive therapy, a single case example is used throughout the book. "Sally," an 18-year-old single Caucasian female, is a nearly ideal patient in many ways and her treatment clearly exemplifies the principles of cognitive therapy. She sought treatment during her second semester of college because she had been feeling quite depressed and moderately anxious for the previous four months and was having difficulty with her daily activities. Indeed, she met criteria for a major depressive episode of moderate severity according to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994). A fuller portrait of Sally is provided in the next chapter and in Appendix A.

The following transcript, excerpted from Sally's fourth therapy session, provides the flavor of a typical cognitive therapy intervention. A problem important to the patient is specified, an associated dysfunctional idea is identified and evaluated, a reasonable plan is devised, and the effectiveness of the intervention is assessed.

THERAPIST: Okay, Sally, you said you wanted to talk about a problem with finding a part-time job?

PATIENT: Yeah. I need the money . . . but, I don't know.

T: (Noticing that the patient looks more dysphoric.) What's going through your mind right now?

P: I won't be able to handle a job.

T: And how does that make you feel?

P: Sad. Really low.

T: So you have the thought, "I won't be able to handle a job," and that thought makes you feel sad. What's the evidence that you won't be able to work?

P: Well, I'm having trouble just getting through my classes.

T: Okay. What else?

P: I don't know. . . . I'm still so tired. It's hard to make myself even go and look for a job, much less go to work every day.

T: In a minute we'll look at that. Maybe it's actually harder for you at this point to go out and *investigate* jobs than it would be for you to go to a job that you already had. In any case, any other evidence that you couldn't handle a job, assuming that you can get one?

P: . . . No, not that I can think of.

T: Any evidence on the other side? That you *might* be able to handle a job?

- ... and beyond
- P: I did work last year. And that was on top of school and other activities. But this year . . . I just don't know.
- T: Any other evidence that you could handle a job?
- P: I don't know. . . . It's possible I could do something that doesn't take much time. And that isn't too hard.
- T: What might that be?
- P: A sales job maybe. I did that last year.
- T: Any ideas of where you could work?
- P: Actually, maybe The [University] Bookstore. I saw a notice that they're looking for new clerks.
- T: Okay. And what would be the *worst* that could happen if you did get a job at the bookstore?
- P: I guess if I couldn't do it.
- T: And you'd live through that?
- P: Yeah, sure. I guess I'd just quit.
- T: And what would be the *best* that could happen?
- P: Uh . . . that I'd be able to do it easily.
- T: And what's the most *realistic* outcome?
- P: It probably won't be easy, especially at first. But I might be able to do it.
- T: What's the effect of believing this original thought, "I won't be able to handle a job."
- P: Makes me feel sad. . . . Makes me not even try.
- T: And what's the effect of changing your thinking, of realizing that possibly you could work in the bookstore?
- P: I'd feel better. I'd be more likely to apply for the job.
- T: So what do you want to do about this?
- P: Go to the bookstore. I could go this afternoon.
- T: How likely are you to go?
- P: Oh, I guess I will. I will go.
- T: And how do you feel now?
- P: A little better. A little more nervous, maybe. But a little more hopeful, I guess.

Here Sally is easily able to identify and evaluate her dysfunctional thought, "I won't be able to handle a job," with standard questions (see

Chapter 8). Many patients, faced with a similar problem, require far more therapeutic effort before they are willing to follow through behaviorally. Although therapy must be tailored to the individual, there are, nevertheless, certain principles that underlie cognitive therapy for all patients.

Principle No. 1. Cognitive therapy is based on an ever-evolving formulation of the patient and her problems in cognitive terms. Sally's therapist seeks to conceptualize her difficulties in three time frames. From the beginning, he identifies her *current thinking* that helps maintain Sally's feelings of sadness ("I'm a failure, I can't do anything right, I'll never be happy") and her *problematic behaviors* (isolating herself, spending an inordinate amount of time in bed, avoiding asking for help). Note that these problematic behaviors both flow from and in turn reinforce Sally's dysfunctional thinking. Second, he identifies *precipitating factors* that influenced Sally's perceptions at the onset of her depression (e.g., being away from home for the first time and struggling in her studies contributed to her belief that she was inadequate). Third, he hypothesizes about *key developmental events* and her *enduring patterns of interpreting* these events that may have predisposed her to depression (e.g., Sally has had a lifelong tendency to attribute personal strengths and achievement to luck but views her [relative] weaknesses as a reflection of her "true" self).

Her therapist bases his formulation on the data Sally provides at their very first meeting and continues to refine this conceptualization throughout therapy as more data are obtained. At strategic points, he shares the conceptualization with her to ensure that it "rings true" to her. Moreover, throughout therapy he helps Sally view her experience through the cognitive model. She learns, for example, to identify the thoughts associated with her distressing affect and to evaluate and formulate more adaptive responses to her thinking. Doing so improves how she feels and often leads to her behaving in a more functional way.

Principle No. 2. Cognitive therapy requires a sound therapeutic alliance. Sally, like many patients with uncomplicated depression and anxiety disorders, has little difficulty trusting and working with her therapist, who demonstrates all the basic ingredients necessary in a counseling situation: warmth, empathy, caring, genuine regard, and competence. Her therapist shows his regard for Sally by making empathic statements, listening closely and carefully, accurately summarizing her thoughts and feelings, and being realistically optimistic and upbeat. He also asks Sally for feedback at the end of each session to ensure that she feels understood and positive about the session.

Other patients, particularly those with personality disorders, require a far greater emphasis on the therapeutic relationship in order to forge a good working alliance (Beck et al., 1990; Young, 1990). Had Sally

quired it, her therapist would have spent more time building the
ance through various means, including having Sally periodically
identify and evaluate her thoughts about him.

Principle No. 3. Cognitive therapy emphasizes collaboration and active participation. Sally's therapist encourages her to view therapy as team-work; together they decide such things as what to work on each session, how often they should meet, and what Sally should do between sessions for therapy homework. At first, her therapist is more active in suggesting a direction for therapy sessions and in summarizing what they have discussed during a session. As Sally becomes less depressed and more socialized into therapy, her therapist encourages her to become increasingly active in the therapy session: deciding which topics to talk about, identifying the distortions in her thinking, summarizing important points, and devising homework assignments.

Principle No. 4. Cognitive therapy is goal oriented and problem focused. Sally's therapist asks her in their initial session to enumerate her problems and set specific goals. For example, an initial problem involves feeling isolated. With guidance, Sally states a goal in behavioral terms: to initiate new friendships and become more intimate with current friends. Her therapist helps her evaluate and respond to thoughts that interfere with her goal, such as, "I have nothing to offer anyone. They probably won't want to be with me." First, he helps Sally evaluate the validity of these thoughts in the office through an examination of the evidence. Then Sally is willing to test the thoughts more directly through experiments in which she initiates plans with an acquaintance and a friend. Once she recognizes and corrects the distortion in her thinking, Sally is able to benefit from straightforward problem-solving to improve her relationships.

Thus, the therapist pays particular attention to the obstacles that prevent the patient from solving problems and reaching goals herself. Many patients who functioned well before the onset of their disorder may not need direct training in problem-solving. Instead, they benefit from evaluation of dysfunctional ideas that impede their use of their previously acquired skills. Other patients are deficient in problem-solving and do need direct instruction to learn these strategies. The therapist, therefore, needs to conceptualize the individual patient's specific difficulties and assess the appropriate level of intervention.

Principle No. 5. Cognitive therapy initially emphasizes the present. The treatment of most patients involves a strong focus on current problems and on specific situations that are distressing to the patient. Resolution and/or a more realistic appraisal of situations that are currently distress-

ing usually lead to symptom reduction. The cognitive therapist, therefore, generally tends to start therapy with an examination of here-and-now problems, regardless of diagnosis. Attention shifts to the past in three circumstances: when the patient expresses a strong predilection to do so; when work directed toward current problems produces little or no cognitive, behavioral, and emotional change; or when the therapist judges that it is important to understand how and when important dysfunctional ideas originated and how these ideas affect the patient today. Sally's therapist, for example, discusses childhood events with her midway through therapy to help her identify a set of beliefs she learned as a child: "If I achieve highly, it means I'm an okay person," and "If I don't achieve highly, it means I'm a failure." Her therapist helps her evaluate the validity of these beliefs both in the past and present. Doing so leads Sally, in part, to the development of more functional, more reasonable beliefs. If Sally had had a personality disorder, her therapist would have spent proportionally more time discussing her developmental history and childhood origin of beliefs and coping behaviors.

Principle No. 6. Cognitive therapy is educative, aims to teach the patient to be her own therapist, and emphasizes relapse prevention. In their first session, Sally's therapist educates her about the nature and course of her disorder, about the process of cognitive therapy, and about the cognitive model (i.e., how her thoughts influence her emotions and behavior). He not only helps her to set goals, identify and evaluate thoughts and beliefs, and plan behavioral change, but also teaches her *how* to do so. At each session, he encourages Sally to record in writing important ideas she has learned so she can benefit from her new understanding in the ensuing weeks and also after the end of their therapy together.

Principle No. 7. Cognitive therapy aims to be time limited. Most straightforward patients with depression and anxiety disorders are treated for 4 to 14 sessions. Sally's therapist has the same goals for her as for all his patients: to provide symptom relief, to facilitate a remission of the disorder, to help her resolve her most pressing problems, and to teach her tools so that she will more likely avoid relapse. Sally initially has weekly therapy sessions. (Had her depression been more severe or had she been suicidal, they may have arranged more frequent sessions.) After 2 months, they collaboratively decide to experiment with biweekly sessions, then with monthly sessions. Even after termination, they plan periodic "booster" sessions every 3 months for a year.

Not all patients make enough progress in just a few months, however. Some patients require 1 or 2 years of therapy (or possibly longer) to modify very rigid dysfunctional beliefs and patterns of behavior that contribute to their chronic distress.

Principle No. 8. Cognitive therapy sessions are structured. No matter what the diagnosis or stage of treatment, the cognitive therapist tends to adhere to a set structure in every session. Sally's therapist checks her mood, asks for a brief review of the week, collaboratively sets an agenda for the session, elicits feedback about the previous session, reviews homework, discusses the agenda items, sets new homework, frequently summarizes, and seeks feedback at the end of each session. This structure remains constant throughout therapy. As Sally becomes less depressed, her therapist encourages her to take more of a lead in contributing to the agenda, setting her homework assignments, and evaluating and responding to her thoughts. Following a set format makes the process of therapy more understandable for both Sally and her therapist and increases the likelihood that Sally will be able to do self-therapy after termination. This format also focuses attention on what is most important to Sally and maximizes use of therapy time.

Principle No. 9. Cognitive therapy teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs. The transcript presented earlier in this chapter illustrates how Sally's therapist helps her focus on a specific problem (finding a part-time job), identify her dysfunctional thinking (by asking what was going through her mind), evaluate the validity of her thought (through examining the evidence that seems to support its accuracy and the evidence that seems to contradict it), and devise a plan of action. He does so through gentle *Socratic questioning*, which helps foster Sally's sense that he is truly interested in *collaborative empiricism*, that is, helping her determine the accuracy and utility of her ideas via a careful review of data (rather than challenging her or persuading her to adopt his viewpoint). In other sessions he uses *guided discovery*, a process in which he continues to ask Sally the meaning of her thoughts in order to uncover underlying beliefs she holds about herself, her world, and other people. Through questioning he also guides her in evaluating the validity and functionality of her beliefs.

Principle No. 10. Cognitive therapy uses a variety of techniques to change thinking, mood, and behavior. Although cognitive strategies such as Socratic questioning and guided discovery are central to cognitive therapy, techniques from other orientations (especially behavior therapy and Gestalt therapy) are also used within a cognitive framework. The therapist selects techniques based on his case formulation and his objectives in specific sessions.

These basic principles apply to all patients. Therapy does, however, vary considerably according to the individual patient, the nature of her difficulties, her goals, her ability to form a strong therapeutic bond, her motivation to change, her previous experience with therapy, and her

preferences for treatment. The *emphasis* in treatment depends on the patient's particular disorder(s). Cognitive therapy for generalized anxiety disorder, for example, emphasizes the reappraisal of risk in particular situations and one's resources for dealing with threat (Beck & Emery, 1985). Treatment for panic disorder involves the testing of the patient's catastrophic misinterpretations (usually life- or sanity-threatening erroneous predictions) of bodily or mental sensations (Clark, 1989). Anorexia requires a modification of beliefs about personal worth and control (Garner & Bemis, 1985). Substance abuse treatment focuses on negative beliefs about the self and facilitating or permission granting beliefs about substance use (Beck, Wright, Newman, & Liese, 1993). Brief descriptions of these and other disorders can be found in Chapter 16.

DEVELOPING AS A COGNITIVE THERAPIST

To the untrained observer, cognitive therapy sometimes appears deceptively simple. The *cognitive model*, that one's thoughts influence one's emotions and behavior, is quite straightforward. Experienced cognitive therapists, however, accomplish many tasks at once: conceptualizing the case, building rapport, socializing and educating the patient, identifying problems, collecting data, testing hypotheses, and summarizing. The novice cognitive therapist, in contrast, usually needs to be more deliberate and structured, concentrating on one element at a time. Although the ultimate goal is to interweave the elements and conduct therapy as effectively and efficiently as possible, beginners must first master the technology of cognitive therapy, which is best done in a straightforward manner.

Developing expertise as a cognitive therapist can be viewed in three stages. (These descriptions presuppose the therapist's proficiency in demonstrating empathy, concern, and competence to patients.) In Stage 1, therapists learn to structure the session and to use basic techniques. Equally important, they learn basic skills of conceptualizing a case in cognitive terms based on an intake evaluation and data gained in session.

In Stage 2, therapists begin integrating their conceptualization with their knowledge of techniques. They strengthen their ability to understand the flow of therapy and are more easily able to identify critical goals of therapy. Therapists become more skillful at conceptualizing patients, refining their conceptualization during the therapy session itself, and using the conceptualization to make decisions about interventions. They expand their repertoire of techniques and become more proficient in selecting, timing, and implementing appropriate techniques.

Therapists at Stage 3 more automatically integrate data into the conceptualization. They refine their ability to make hypotheses to con-

...m or disconfirm their view of the patient. They vary the structure
...niques of basic cognitive therapy as appropriate, particularly for
difficult cases such as personality disorders.