

# Cognitive Therapy

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Cognitive therapy, a system developed by Aaron Beck, stresses the importance of belief systems and thinking in determining behavior and feelings. The focus of cognitive therapy is on understanding distorted beliefs and using techniques to change maladaptive thinking while also incorporating affective and behavioral methods. In the therapeutic process, attention is paid to thoughts that individuals may be unaware of and to important belief systems.

Working collaboratively with clients, cognitive therapists take an educational role, helping clients understand distorted beliefs and suggesting methods for changing these beliefs. In doing so, cognitive therapists may give clients assignments to test out new alternatives to their old ways of solving their problems. As the therapist gathers data to determine therapeutic strategies, clients may be asked to record dysfunctional thoughts and to assess their problems through brief questionnaires developed for a variety of different psychological disorders. In their approach to treatment, cognitive therapists have outlined types of maladaptive thinking and specific treatment strategies for many psychological disturbances, including depression and anxiety disorders.

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## HISTORY OF COGNITIVE THERAPY

Although several theories of psychotherapy emphasize cognitive aspects of treatment, cognitive therapy is associated with the work of Aaron Beck. Born in 1921, Beck received his doctor of medicine degree from Yale University in 1946. From 1946 to 1948 he served an internship and residency in pathology at the Rhode Island Hospital in Providence. Following that experience, he was a resident in neurology, then later in psychiatry at the Cushing Veterans Administration Hospital in Framingham, Massachusetts. Also, he was a fellow in psychiatry at the Austen Riggs Center in Stockbridge, Massachusetts. In 1953, he was certified in psychiatry by the American Board of Psychiatry and Neurology. In 1956, he graduated from the Philadelphia Psychoanalytic Institute. He joined the faculty of the Department of Psychiatry of the Medical School of the University of Pennsylvania, where he is now Professor Emeritus. His early research on depression (Beck, 1961, 1964) led to publication of *Depression*:



AARON BECK

*Clinical, Experimental, and Theoretical Aspects* (1967), which discussed the importance of cognition in treating depression. Since then he has authored or coauthored more than 400 articles and 15 books related to cognitive therapy and the treatment of a variety of emotional disorders.

Originally a practicing psychoanalyst, Beck (2001a) observed the verbalizations and free associations of his patients. Surprised that his patients experienced thoughts they were barely aware of and did not report as a part of their free associations, he drew his patients' attention to these thoughts. Appearing quickly and automatically, these thoughts or cognitions were not within the patients' control. Often these automatic thoughts that patients were unaware of were followed by unpleasant feelings they were very much aware of (Beck, 1991). By asking patients about their current thoughts, Beck was able to identify negative themes, such as defeat or inadequacy, that characterized their view of past, present, and future.

Having been trained as a psychoanalyst, Beck compared his observation of automatic thoughts to Freud's concept of the "preconscious." Beck (1976) was interested in what people said to themselves and the way they monitored themselves—their own internal communication system. From the internal communications within themselves, individuals formed sets of beliefs, an observation reported earlier by Ellis (1962). From these important beliefs, individuals formulated rules or standards for themselves, called schemas, or thought patterns that determine how experiences will be perceived or interpreted. Beck noticed that his patients, particularly those who were depressed, used internal conversations that communicated self-blame and self-criticism. Such patients often predicted failure or disaster for themselves and made negative interpretations where positive ones would have been more appropriate.

From these observations, Beck formulated the concept of a negative cognitive shift, in which individuals ignore much positive information relevant to themselves and focus instead on negative information about themselves. To do so, patients may distort observations of events by exaggerating negative aspects, looking at things as all black or all white. Comments such as "I never can do anything right," "Life will never treat me well," and "I am hopeless" are examples of statements that are overgeneralized, exaggerated, and abstract. Beck found such thinking, typical of individuals who are depressed, to be automatic and to occur without awareness. Many of these thoughts developed into beliefs about worthlessness, being unlovable, and so forth. Such beliefs, Beck (1967) hypothesized, were formed at earlier stages in life and became significant cognitive schemas. For example, a student who has several exams coming up in the next week may say to herself, "I'll never pass, I can't do anything right." Such an expression is a verbalization of a cognitive schema indicating a lack of self-worth. The student may express such a belief despite the fact that she is well prepared for her exams and has done well previously in her schoolwork. Thus, the beliefs persist despite evidence that contradicts them.

Although Beck's early work focused on depression, he applied his concepts of automatic thoughts, distorted beliefs, and cognitive schemas to other disorders. For example, he explained anxiety disorders as dominated by threat of failure or abandonment.

From observations of patients and going over transcripts of sessions, Beck identified cognitive schemas that were common to people with different types of emotional disorders and developed strategies for treating them.

### **Theoretical Influences**

Although much of Beck's theory of cognitive psychotherapy is based on observations from his clinical work, he and his colleagues have also been somewhat influenced by other theories of psychotherapy, cognitive psychology, and cognitive science. Because of his training as a psychoanalyst, Beck drew some concepts from psychoanalysis into his own work. Furthermore, there are similarities between cognitive therapy and the work of Albert Ellis and Alfred Adler, notably their emphasis on the importance of beliefs. Also, George Kelly's theory of personal constructs and Jean Piaget's work on the development of cognition play a role in understanding cognitions in personality. Attempts to develop computer models of intellectual thinking, an aspect of cognitive science, also contributed to the continuing development of cognitive psychotherapy.

Psychoanalysis and cognitive therapy share the view that behavior can be affected by beliefs that individuals have little or no awareness of. Whereas Freud hypothesized about unconscious thoughts, Beck has focused on automatic thoughts that can lead to distress. It was Freud's theory that anger, when turned inward, becomes depression that started Beck on his path for understanding the process of depression. Thus, Freud's theories of psychological disorders became the starting point from which cognitive therapy developed. This fact is not readily apparent, as the cognitive view of personality and techniques of psychotherapeutic change are very different from those of psychoanalysis.

More similar in theory and practice are the ideas of Adler, who emphasized the cognitive nature of individuals and their beliefs. Although Adlerians have focused on the development of beliefs, more so than Beck, they also have created a number of strategies to bring about changes in perceptions. Both Adler and Beck share an active approach to therapy, using specific and direct dialogue with patients to bring about change.

Similarly, Albert Ellis (1962) has used active and challenging approaches to confront irrational beliefs. Both Beck and Ellis challenge their patients' belief systems through direct interaction. They believe that by changing inaccurate assumptions, clients can make important changes to overcome psychological disorders. Although there are clear differences, which are discussed later, the commonalities between Beck's and Ellis's systems have served to strengthen the impact of cognitive therapies on the field of psychotherapy, both through the writings of the two theorists and the extensive research on the effectiveness of both approaches.

Although not as directly related to cognitive therapy as the work of psychotherapists, Kelly's theory of personal constructs explores the role of cognitions in personality development. Describing his basic construct of personality, Kelly (1955) said, "A person's processes are psychologically channelized by the way in which he anticipates events" (p. 46). Seeing constructs as individual, dichotomous, and covering a finite range of events, Kelly believed that individuals have a system of personal constructs that express their views of the world. For example, "smart-stupid" may be a personal construct, a way we view our acquaintances and friends. Not all people would construe events in this way, and some may have other constructs such as "strong-weak" that explain the way they see others. There is a resemblance between Kelly's personal

constructs and Beck's schemas, in that both describe ways of characterizing individuals' systems of beliefs. Also, both theorists share an emphasis on the role of beliefs in changing behavior.

A very different approach to studying cognition was taken by Piaget, who was interested in the way individuals learn. In his studies of children's intellectual skills, Piaget (1977) described four major periods of cognitive development: sensorimotor, preoperations, concrete operations, and formal operations. The sensorimotor stage occurs from birth to age 2 and describes the learning that takes place when infants learn by touching, seeing, hitting, screaming, and so forth. The preoperations stage (ages 2 to about 7) includes basic intellectual skills like adding and subtracting. In the third stage, concrete operations, ages 7 to 11, children are better able to tell fantasy from reality and do not have to see an object to imagine manipulating it. They can deal with the concept of adding 4 tigers to 3 tigers, but they cannot add  $4z$  to  $7z$ . This ability takes place in the fourth stage, formal operations, and requires abstract learning. In discussing the implication of Piaget's theory for psychotherapy, Ronen (1997) has described how it can be helpful to match psychotherapeutic techniques of cognitive therapy with the individual's stage of cognitive development.

A broad and developing area of research that has the potential to contribute much to the cognitive theory of psychotherapy is cognitive science. Basically, cognitive science is interested in understanding how the mind works and in developing models for intellectual functioning. Involving such fields as cognitive psychology, artificial intelligence, linguistics, neuroscience, anthropology, and philosophy, cognitive science provides many perspectives on human intellectual processing. In cognitive psychology, researchers have studied how individuals make choices, remember facts, learn rules, remember events selectively, and learn differentially (Stein & Young, 1992).

### Current Influences

Research in cognitive psychology and related fields is important in advancing new techniques in cognitive therapy. As is shown later, outcome research is an important part of the development of new methods and the testing of the effectiveness of cognitive therapy. This research is published widely in cognitive therapy journals such as *Cognitive Therapy and Research*, *Journal of Cognitive Psychotherapy: An International Quarterly*, and *Cognitive and Behavioral Practice*. Additionally, research studies are published in a variety of behavior therapy and other psychological journals. Information from this work is used in teaching individuals at training centers for cognitive therapy in the United States. In particular, the Beck Institute for Cognitive Therapy and Research in Bala Cynwyd, Pennsylvania, has a large program devoted to training therapists and bringing in visiting scholars to participate in research and clinical activities. Started in 1959, cognitive therapy has become increasingly popular, perhaps due to the specificity of its techniques and the positive results of outcome research.

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## COGNITIVE THEORY OF PERSONALITY

Cognitive therapists are particularly concerned with the impact of thinking on individuals' personalities. Although cognitive processes are not considered to be the cause

of psychological disorders, they are a significant component. In particular, automatic thoughts that individuals may not be aware of can be significant in personality development. Such thoughts are an aspect of the individual's beliefs or cognitive schemas, which are important in understanding how individuals make choices and draw inferences about their lives. Of particular interest in understanding psychological disorders are cognitive distortions, inaccurate ways of thinking that contribute to unhappiness and dissatisfaction in the lives of individuals.

### **Causation and Psychological Disorders**

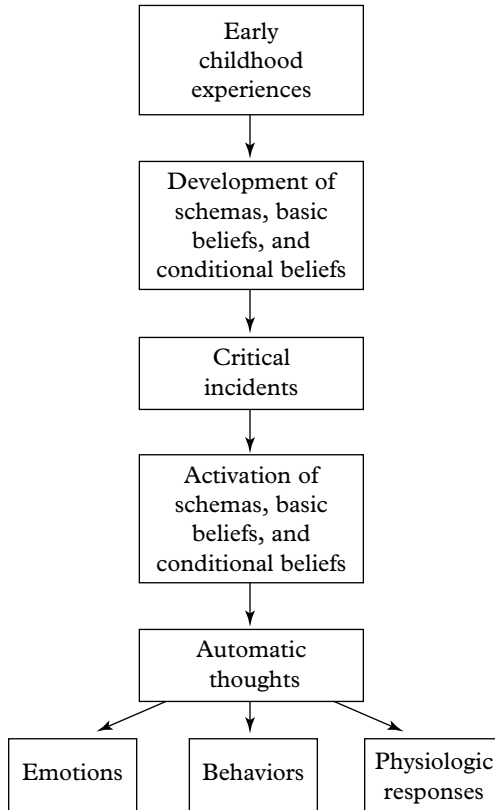
As Beck (1967; Clark & Beck, 1999) has said, psychological distress can be caused by a combination of biological, environmental, and social factors, interacting in a variety of ways, so that there is rarely a single cause for a disorder. Sometimes early childhood events may lead to later cognitive distortions. Lack of experience or training may lead to ineffective or maladaptive ways of thinking, such as setting unrealistic goals or making inaccurate assumptions (DeRubeis, Tang, & Beck, 2001). At times of stress, when individuals anticipate or perceive a situation as threatening, their thinking may be distorted. It is not the inaccurate thoughts that cause the psychological disorder; rather, it is a combination of biological, developmental, and environmental factors (Beck & Weishaar, 1989). Regardless of the cause of the psychological disturbance, automatic thoughts are likely to be a significant part of the processing of the perceived distress.

### **The Cognitive Model of Development**

Cognitive therapists view individual beliefs as beginning in early childhood and developing throughout life (Figure 10.1). Early childhood experiences lead to basic beliefs about oneself and one's world. Normally, individuals experience support and love from parents, which lead to beliefs such as "I am lovable" and "I am competent," which in turn lead to positive views of themselves in adulthood. Persons who develop psychological dysfunctions, in contrast to those with healthy functioning, have negative experiences that may lead to beliefs such as "I am unlovable" and "I am inadequate." These developmental experiences, along with critical incidents or traumatic experiences, influence individuals' belief systems. Negative experiences, such as being ridiculed by a teacher, may lead to conditional beliefs such as "If others don't like what I do, I am not valuable." Such beliefs may become basic to the individual as negative cognitive schemas.

### **Automatic Thoughts**

As mentioned previously, the automatic thought is a key concept in Beck's cognitive psychotherapy. Such thoughts occur spontaneously, without effort or choice. In psychological disorders, automatic thoughts are often distorted, extreme, or otherwise inaccurate. For example, Nancy put off applying to department stores for a job as an assistant buyer. Unhappy with her job as a sales clerk, she had such thoughts as "I'm too busy now," "When the holiday season is over, I will apply for a job," and "I cannot get time off to go to other stores to get job applications." Recognizing these thoughts as



**FIGURE 10.1** The Cognitive Developmental Model.

From “Brief Therapy, Crisis Intervention and the Cognitive Therapy of Substance Abuse,” by B. S. Liese, 1994, *Crisis Intervention, 1*, 11–29. Copyright © 1994 by Harwood Academic Publishers. Reprinted by permission.

excuses, Nancy, with the help of her therapist, identified automatic thoughts related to job seeking, such as “I won’t present myself well” and “Other people will be better than me.” By talking with Nancy about her thought processes, the therapist was able to generate several automatic thoughts. By organizing these automatic thoughts, the therapist was able to articulate a set of core beliefs or schemas.

### Cognitive Schemas

How individuals think about their world and their important beliefs and assumptions about people, events, and the environment constitute cognitive schemas. There are two basic types of cognitive schemas: positive (adaptive) and negative (maladaptive). What can be an adaptive schema in one situation may be maladaptive in another. Freeman (1993) gives an example of a schema that can be both positive and negative, depending on the circumstance.

Allen was a 67-year-old male. He had recently retired as chief executive officer of a large international firm. He had worked himself up in the company from the lowest level as a high school student to the chief position over a period of 50 years. In his retirement, he was physically healthy, had a great deal of money, good marital and family relationships, and a circle of friends. When he came for therapy he was, however, moderately to severely depressed. The operative schemas that drove him to success—that is, “I am what I do or produce,” “One is judged by others by one’s productivity,” and “If one isn’t working, one is lazy/worthless” were now contributing to his depression. The schemas were the same, but the effect on his life was far different. (p. 60)<sup>1</sup>

In describing schemas, Beck and Weishaar (1989) note that schemas develop early in life from personal experience and interaction with others. Some of the schemas are associated with cognitive vulnerability or a predisposition to psychological distress. For example, individuals who are depressed may have negative schemas such as “I can’t do anything right,” “I won’t amount to anything,” and “Other people are much more adept than I.” In this way, cognitive vulnerability can be seen in distorted or negative schemas.

When a patient presents a negative schema, the therapist may note a cognitive shift. For each psychological disorder, particular cognitive distortions are likely to be present. By diagnosing the disorder, the therapist can understand how the client integrates data and acts in accordance with the data. Thus, an anxious client may perceive a threat while driving home and take a prescribed route that may include alternates in case traffic jams or accidents are seen ahead. By observing the client describing this situation, the therapist may perceive an affective shift that indicates that the client has made a cognitive shift. Signals of such a shift may be facial or bodily expressions of emotion or stress. When such an event takes place in therapy, the cognitive schema may be emotional or “hot.” In such a case, the therapist is likely to follow up the “hot” cognition with a question such as “What were you thinking just now?” (Beck, Emery, & Greenberg, 1985).

In further describing schemas, Clark and Beck (1999) list five types of schemas: cognitive-conceptual, affective, physiological, behavioral, and motivational. *Cognitive-conceptual schemas* provide a way for storing, interpreting, and making meaning of our world. Core beliefs are cognitive-conceptual schemas. *Affective schemas* include both positive and negative feelings. *Physiological schemas* are those that include perceptions of physical functions, such as a panic reaction that could include hyperventilating. *Behavioral schemas* are actions that are taken, such as running away when scared. *Motivational schemas* are related to behavioral schemas in that they often initiate an action. Examples of motivational schemas include the desire to avoid pain, to eat, to study, and to play. These schemas can be adaptive or maladaptive.

A different approach to schemas, one that is particularly appropriate with clients with personality disorders, has been taken by Freeman (1993), who emphasizes the developmental aspects of cognitive schemas. Adapting Erikson’s (1950) model of psychosocial development, Freeman focuses on the social context of the individual, which would include relationships with family, school, friends, and work. By using Erikson’s eight stages of development, Freeman is able to conceptualize schemas that develop out of crises at various periods throughout the life span. For example, Erikson’s (1950) first stage is that of trust versus mistrust. A schema of trust might arise from thoughts

such as “I can rely on others” and “People are here to help me,” whereas a schema of mistrust might include automatic thoughts such as “I can’t count on anyone” and “People will do what they want despite my wishes.” Freeman describes other automatic thoughts that are present in schemas that can be derived from the other seven stages of Erikson’s model of psychosocial development.

### Cognitive Distortions

An individual’s important beliefs or schemas are subject to cognitive distortion. Because schemas often start in childhood, the thought processes that support schemas may reflect early errors in reasoning. Cognitive distortions appear when information processing is inaccurate or ineffective. In his original work with depression, Beck (1967) identified several significant cognitive distortions that can be identified in the thought processes of depressed people. Freeman (1987) and DeRubeis, Tang, and Beck (2001) have discussed a variety of common cognitive distortions that can be found in different psychological disorders. Nine of these are described here: all-or-nothing thinking, selective abstraction, mind reading, negative prediction, catastrophizing, overgeneralization, labeling and mislabeling, magnification or minimization, and personalization.

**All-or nothing thinking.** By thinking that something has to be either exactly as we want it or it is a failure, we are engaging in all-or-nothing, or dichotomous, thinking. A student who says “Unless I get an A on the exam, I have failed” is engaging in all-or-nothing thinking. Grades of A- and B+ then become failures and are seen as unsatisfactory.

**Selective abstraction.** Sometimes individuals pick out an idea or fact from an event to support their depressed or negative thinking. For example, a baseball player who has had several hits and successful fielding plays may focus on an error he has made and dwell on it. Thus, the ballplayer has selectively abstracted one event from a series of events to draw negative conclusions and to feel depressed.

**Mind reading.** This refers to the idea that we know what another person is thinking about us. For example, a man may conclude that his friend no longer likes him because he will not go shopping with him. In fact, the friend may have many reasons, such as other commitments, not to go shopping.

**Negative prediction.** When an individual believes that something bad is going to happen, and there is no evidence to support this, this is a negative prediction. A person may predict that she may fail an exam, even though she has done well on exams before and is prepared for the upcoming exam. In this case, the inference about failure—the negative prediction—is not supported by the facts.

**Catastrophizing.** In this cognitive distortion, individuals take one event they are concerned about and exaggerate it so that they become fearful. Thus, “I know when I meet the regional manager, I’m going to say something stupid that will jeopardize my

job. I know I will say something that will make her not want to consider me for advancement” turns an important meeting into a possible catastrophe.

**Overgeneralization.** Making a rule based on a few negative events, individuals distort their thinking through overgeneralization. For example, a high school sophomore may conclude: “Because I did poorly on my first algebra exam, I can’t do math.” Another example would be the person who thinks because “Alfred and Bertha were angry at me, my friends won’t like me, and won’t want to have anything to do with me.” Thus, a negative experience with a few events can be generalized into a rule that can affect future behavior.

**Labeling and mislabeling.** A negative view of oneself is created by self-labeling based on some errors or mistakes. A person who has had some awkward incidents with acquaintances might conclude, “I’m unpopular. I’m a loser” rather than “I felt awkward talking to Harriet.” In labeling and mislabeling in this way, individuals can create an inaccurate sense of themselves or their identity. Basically, labeling or mislabeling is an example of overgeneralizing to such a degree that one’s view of oneself is affected.

**Magnification or minimization.** Cognitive distortions can occur when individuals magnify imperfections or minimize good points. They lead to conclusions that support a belief of inferiority and a feeling of depression. An example of magnification is the athlete who suffers a muscle pull and thinks, “I won’t be able to play in the game today. My athletic career is probably over.” In contrast, an example of minimization would be the athlete who would think, “Even though I had a good day playing today, it’s not good enough. It’s not up to my standards.” In either magnification or minimization, the athlete is likely to feel depressed.

**Personalization.** Taking an event that is unrelated to the individual and making it meaningful produces the cognitive distortion of personalization. Examples include “It always rains when I am about to go for a picnic” and “Whenever I go to the shopping center, there is always an incredible amount of traffic.” People do not cause the rain or the traffic; these events are beyond our control. Furthermore, when people are questioned, they are able to give instances of how it does not always rain when they have planned an outdoor function and that they do not always encounter the same level of traffic when shopping. For example, traffic is usually heavier at certain times of day than at others, and if one chooses to shop at a particular time, there will be more or less traffic.

If they occur frequently, such cognitive distortions can lead to psychological distress or disorders. Making inferences and drawing conclusions from a behavior are important parts of human functioning. Individuals must monitor what they do and assess the likelihood of outcomes to make plans about their social lives, romantic lives, and careers. When cognitive distortions are frequent, individuals can no longer do this successfully and may experience depression, anxiety, or other disturbances. Cognitive therapists look for cognitive distortions and help their patients understand their mistakes and make changes in their thinking.

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## THEORY OF COGNITIVE THERAPY

Characterized as a collaborative relationship, therapists work together with their clients to change thinking patterns, as well as behaviors, that interfere with the clients' goals. The establishment of a caring therapeutic relationship is essential. Cognitive therapy is characterized by its careful approach to detail and the role of the thinking process in behavioral and affective change. In setting goals, cognitive therapists attend to faulty beliefs that interfere with individuals achieving their goals. This is reflected in assessment methods that require individuals to monitor, log, and indicate in a variety of ways their cognitions, feelings, and behaviors. A characteristic of cognitive therapy is that the therapist and client collaborate to reach the patient's goals by using a format that allows for feedback and discussion of client progress. Although therapeutic techniques used to bring about change include cognitive, affective, and behavioral elements, the cognitive approaches to changing automatic thoughts and cognitive schemas are emphasized here.

### Goals of Therapy

The basic goal of cognitive therapy is to remove biases or distortions in thinking so that individuals may function more effectively. Attention is paid to the way individuals process information, which may maintain feelings and behaviors that are not adaptive. Patients' cognitive distortions are challenged, tested, and discussed to bring about more positive feelings, behaviors, and thinking.

In establishing goals, cognitive therapists focus on being specific, prioritizing goals, and working collaboratively with clients. The goals may have affective, behavioral, and cognitive components, as seen by this example from Freeman, Pretzer, Fleming, and Simon (1990):

Frank, a depressed salesman, initially stated his goal for therapy as, "to become the best that I can be." When stated in that way, the goal is quite vague and abstract. It also was clearly unmanageable, considering that Frank was so depressed that he could not manage to revise his resumé or do household chores. After considerable discussion, Frank and his therapist agreed on more specific goals including "feel less depressed and anxious, decrease amount of time spent worrying, and actively hunt for a job (revise resumé, actively search for job openings, complete applications for appropriate openings, etc.)." (pp. 10–11)<sup>2</sup>

The clearer and more concrete the goals, the easier it is for therapists to select methods to use in helping individuals change their belief systems and also their feelings and behaviors.

### Assessment in Cognitive Therapy

Careful attention is paid to assessment of client problems and cognitions, both at the beginning of therapy and throughout the entire process, so that the therapist may clearly conceptualize and diagnose the client's problems. As assessment proceeds, it focuses not only on the client's specific thoughts, feelings, and behaviors but also on the

effectiveness of therapeutic techniques as they affect these thoughts, feelings, and behaviors. Specific strategies for assessment have been devised for many different psychological disorders, such as anxiety and depression (J.S. Beck, 1995). In this section, I describe ways cognitive therapists use assessment techniques, including client interviews, self-monitoring, thought sampling, the assessment of beliefs and assumptions, and self-report questionnaires (Freeman et al., 1990).

**Interviews.** In the initial evaluation, the cognitive therapist may wish to get an overview of a variety of topics while at the same time creating a good working relationship with the client. The topics covered are similar to those assessed by many other therapists and include the presenting problem, a developmental history (including family, school, career, and social relationships), past traumatic experiences, medical and psychiatric history, and client goals. In making this assessment, Kendall (1981) suggests that specific questions rather than broad, open-ended questions may yield more accurate information. Freeman et al. (1990) emphasize the importance of getting detailed reports of events. They caution against asking biased questions such as “Didn’t you want to go to work?” and suggest instead “What happened when you did not get to work?” In assessing thoughts, therapists may need to train their clients to differentiate between thoughts and feelings and to report observations rather than make inferences about the observations. Accuracy of recall is encouraged (although clients are not expected to remember all details) and is preferred to guesses about past events. Sometimes in vivo interviews and observations may be of particular help. For example, if a client suffers from agoraphobia, the therapist may meet the client at home and walk outside with the client, making observations and assessments in the interviewing process.

Keeping notes of patients’ experiences, emotions, and behaviors is very helpful. Judith Beck (1995) has developed a Cognitive Conceptualization Diagram (Figure 10.2) to organize patient data. The therapist starts at the bottom half of the diagram, taking each situation one at a time. For example, Fred has been very frightened of presenting at his senior recital at college. He is afraid he will sing off key and embarrass himself in front of the music faculty. Under Situation #1, the therapist would write “Presenting at a recital. Evaluated by 3 music professors.” The therapist then helps Fred in determining the automatic thought and writes it in the box below “Situation #1”—“The professors will think I’m terrible.” Then they determine the “Meaning of A. T.,” which for Fred is “I fold under pressure.” The “Emotion” is “anxiety.” His “Behavior” is “Singing the song he will present, 5 times.” As the therapist and Fred continue, they will discuss at least two more situations in the same way. Each time, the therapist and Fred determine the automatic thoughts, their meaning, the emotion relevant to the situation, and the behavior.

When the therapist has enough information to assess core beliefs, she will integrate information she has about Fred’s “Relevant Childhood Data” with information from the material she has just gathered to determine Fred’s “Core Beliefs.” Then she uses “if-then” phrases to determine “Conditional Assumptions/Beliefs/Rules.” For Fred, his “Core Belief” may be “I’m not good enough.” His “Conditional Assumptions/Beliefs/Rules” may be “If I have to be on my own, I’ll screw up.” This is a negative assumption. A positive assumption would be “When I’m with others (e.g., singing in a chorus), I’m OK.” The final box is “Compensatory Strategies.” Fred’s are “practice,

Pt's Initials:

Therapist's Name:

Pt's Diagnosis: Axis I:

Axis II:

### COGNITIVE CONCEPTUALIZATION DIAGRAM

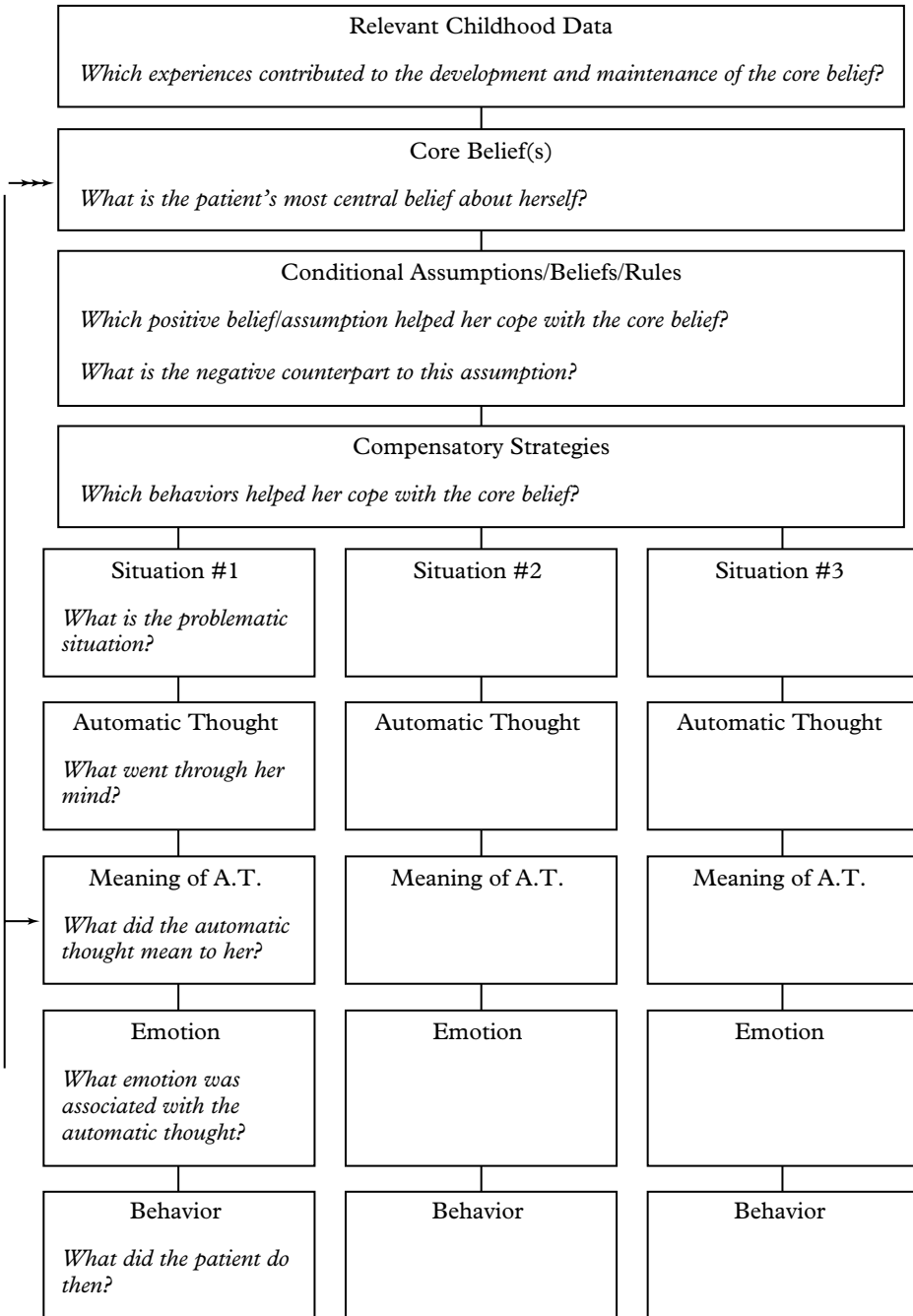


FIGURE 10.2 Cognitive Conceptualization Diagram.

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practice, practice” and “keep telling my girlfriend how nervous I am.” This information then becomes material the therapist uses when developing change strategies. Although the interview is probably the most important way to gather information, cognitive therapists also ask clients to gather specific information on their own.

**Self-monitoring.** Another method used to assess client thoughts, emotions, and behaviors outside the therapist’s office is self-monitoring. Basically, clients keep a record of events, feelings, and/or thoughts. This could be done in a diary, on an audiotape, or by filling out a questionnaire. One of the most common methods is the Dysfunctional Thought Record (DTR) (Beck, Rush, Shaw, & Emery, 1979) (Figure 10.3). Sometimes called a thought sheet, the DTR has one column in which the client describes the situation, a second in which the client rates and identifies an emotion, and a third to record her automatic thoughts. Clients may practice using the DTR in therapy, so that they get used to recording automatic thoughts and rating the intensity of feelings. Use of the DTR provides material for discussion in the next session and an opportunity for clients to learn about their automatic thoughts.

**Thought sampling.** Another method for obtaining information about cognitions is thought sampling (Blankstein & Segal, 2001). Having a tone sound at a random interval at home and then recording thoughts is one way to get a sample of cognitive patterns. Clients may then record their thoughts in a tape recorder or notebook. Freeman et al. (1990) give an example of how thought sampling can be productive in therapy.

A middle-aged factory foreman had made good progress in therapy by using DTRs to identify dysfunctional cognitions related to episodes of anger and depression and then “talking back” to the cognitions. However, he began to experience a vague, depressed mood that seemed not to be related to any clear stimuli. He was unable to identify situations or cognitions related to the depressed mood, and therefore was asked to use a thought sampling procedure to collect additional data. When he returned for his next therapy session, a review of the cognitions he had recorded revealed constant ruminative thoughts centering on the theme of “I’m too tired to . . .” It gradually became clear that these ruminative thoughts were responsible for his decreased motivation to deal with problems actively and for his increased depression. (p. 41)

Thought sampling can be useful in getting data that is related to specific situations, such as work and school. However, thought sampling can interrupt the client’s activity and may become irritating. Also, thoughts irrelevant to the client’s problems may be recorded.

**Scales and questionnaires.** In addition to these techniques, previously developed self-report questionnaires or rating scales can be used to assess irrational beliefs, self-statements, or cognitive distortions. Structured questionnaires have been developed for specific purposes, such as the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the Scale for Suicide Ideation (Beck, Kovacs, & Weissman, 1979), and the Dysfunctional Attitude Scale (Weissman, 1979). Questionnaires such as these are usually brief and can be administered at various points in

DYSFUNCTIONAL THOUGHT RECORD (Example)

Directions: When you notice your mood getting worse, ask yourself, "What's going through my mind right now?" and as soon as possible jot down the thought or mental image in the Automatic Thought column.

Date/ Time	Situation 1. What actual event or stream of thoughts, or daydreams, or recollection led to the unpleasant emotion? 2. What (if any) distressing physical sensations did you have?	Automatic Thought(s) 1. What thought(s) and/or image(s) went through your mind? 2. How much did you believe each one at the time?	Emotion(s) 1. What emotion(s) (sad, anxious, angry, etc.) did you feel at the time? 2. How intense (0-100%) was the emotion?	Alternative Response 1. (optional) What cognitive distortion did you make? (e.g., all-or-nothing thinking, mind-reading, catastrophizing.) 2. Use questions at bottom to compose a response to the automatic thought(s). 3. How much do you believe each response?	Outcome 1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0-100%) is the emotion? 3. What will you do? (or did you do?)

Questions to help compose an alternative: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? Could I live through it? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of changing my thinking? (5) What should I do about it? (6) If \_\_\_\_\_ was in the situation and had this thought, what would I tell him/her?  
(friend's name)

FIGURE 10.3 Dysfunctional Thought Record.

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therapy to monitor progress. Additionally, psychological tests such as the Minnesota Multiphasic Personality Inventory may be used for similar purposes.

When gathering data from clients, especially raw data that include automatic thoughts, it is often helpful for the therapist to try to infer themes or cognitive schemas represented by the cognitions. As data are reported from session to session, different cognitive schemas, or insights into them, may develop. Schemas can be seen as hypotheses that the client and counselor are continually testing. Progress can be assessed as patients complete homework, fill out questionnaires, and report automatic thoughts. With progress should come a decrease in the number of cognitive distortions, increased challenges to automatic thoughts, and a decrease in negative feelings and behavior.

### **The Therapeutic Relationship**

Beck's (1976) view of the client-therapist relationship is that it is collaborative. The therapist brings an expertise about cognitions, behaviors, and feelings to guide the client in determining goals for therapy and means for reaching these goals. The clients' contributions to therapy are the raw data for change (thoughts and feelings). They participate in the selection of goals and share responsibility for change. The assessment process is a continually evolving one. As new data are gathered, the therapist and client may develop new strategies. In some ways, the therapeutic process can be seen as a joint scientific exploration in which both therapist and client test new assumptions. In this process, the therapist may use listening skills that focus on the client's feelings, somewhat similar to the approach of Carl Rogers, to further understand the client's concerns and to develop the relationship. Although the cognitive therapist is open to the feedback, suggestions, and concerns of the client, the process of therapy is specific and goal oriented.

### **The Therapeutic Process**

More so than many other theories of therapy, cognitive therapy is structured in its approach. The initial session or sessions deal with assessment of the problem, development of a collaborative relationship, and case conceptualization. As therapy progresses, a guided discovery approach is used to help clients learn about their inaccurate thinking. Other important aspects of the therapeutic process are methods to identify automatic thoughts and the assignment of homework, which is done throughout therapy. As clients reach their goals, termination is planned, and clients work on how they will use what they have learned when therapy has stopped. As therapeutic work progresses, clients move from developing insight into their beliefs to moving toward change. Particularly with difficult and complex problems, insight into the development of negative cognitive schemas is important. All of these aspects of the therapeutic process are described more fully here.

**Guided discovery.** Sometimes called Socratic dialogue, guided discovery helps clients change maladaptive beliefs and assumptions. The therapist guides the client in discovering new ways of thinking and behaving by asking a series of questions that make use of existing information to challenge beliefs.

**Client:** I've been afraid that when I report to my new job on Monday, people will think I can't do the work.

**Therapist:** What does that tell you about the assumptions that you are making?

**Client:** Like I'm mind reading, like I know in advance what's going to happen.

**Therapist:** And what assumptions are you making?

**Client:** That I know what my new colleagues will think of me.

**The three-question technique.** A specific form of the Socratic method, the three-question technique consists of a series of three questions designed to help clients revise negative thinking. Each question presents a way of inquiring further into negative beliefs and bringing about more objective thinking.

1. What is the evidence for the belief?
2. How else can you interpret the situation?
3. If it is true, what are the implications?

A brief example of this technique shows how it is an extension of the Socratic method and how it can help individuals change their beliefs. Liese (1993) gives an example of a physician using the three-question technique with a patient with AIDS.

**Dr.:** Jim, you told me a few minutes ago that some people will scorn you when they learn about your illness. (reflection) What is your *evidence* for this belief?

**Jim:** I don't have any evidence. I just feel that way.

**Dr.:** You "just feel that way." (reflection) How else could you look at the situation?

**Jim:** I guess my real friends wouldn't abandon me.

**Dr.:** If some people did, in fact, abandon you, what would the *implications* be?

**Jim:** I guess it would be tolerable, as long as my real friends didn't abandon me.

(Liese, 1993, p. 83)

**Specifying automatic thoughts.** An important early intervention is to ask the client to discuss and to record negative thoughts. Specifying thoughts using the Dysfunctional Thought Record and bringing them into the next session can be helpful for work in future sessions. An example of automatic thoughts and helping a patient understand them is given here.

During the first session, I had asked my client how often he thought that he had negative thoughts. His response was that he had them at times, but only infrequently. Given his Beck Depression Inventory of 38, my thinking was that he would have many, many more. He estimated no more than two to three a day. As a homework assignment I asked him to record as many of his thoughts as possible. I estimated that he probably had several negative thoughts a day, and that by the end of the week he would probably have 50 thoughts recorded. He quickly responded: "I'll never be able to do it. It would be too hard for me. I'll just fail." My response was to indicate that he already had three and only needed 47 more. (Freeman et al., 1990, pp. 12–13)

**Homework.** Much work in cognitive therapy takes place between sessions. Specific assignments are given to help the client collect data, test cognitive and behavior changes, and work on material developed in previous sessions (Persons, Davidson, & Tompkins, 2001). If the client does not complete the homework, this fact can be useful in examining problems in the relationship between client and therapist or problems in homework assignments that may indicate lack of clarity or other problems. Generally, homework assignments are discussed and new ones developed in each session.

**Session format.** Although therapists may have their own format that they adapt for different client problems, there are certain topics to be dealt with in the therapy session (J. S. Beck, 1995). The therapist checks on the client's mood and how he is feeling. Usually, the therapist and client agree on an agenda for the therapy session based, in part, on a review of events of the past week and on pressing problems that may have emerged. Also, the therapist asks for feedback about the previous session and concerns or problems that the client may have about issues that have occurred since the last meeting. The therapist and client review homework and collaborate to see how the client could get more out of it. Usually, the major focus of the session is on the concerns the client raised at the beginning of the therapy hour. Having dealt with specific items, new homework is assigned relevant to the client's chief concerns. Feedback from the client about the session is an important element of the collaborative relationship between therapist and client.

**Termination.** As early as the first session, termination may be planned. Throughout treatment, therapists encourage patients to monitor their thoughts or behaviors, report them, and measure progress toward their goals. In the termination phase, the therapist and client discuss how the client can do this without the therapist. Essentially, clients become their own therapists. Just as clients may have had difficulties in accomplishing tasks and may have relapsed into old thought patterns or behaviors, they work on how to deal with similar issues and events after therapy has ended. Commonly, the frequency of therapy sessions tapers off, and client and therapist may meet every 2 weeks or once a month.

Although issues occur in therapy that may require changes in the therapeutic process described here, the specificity of the therapeutic approach, the emphasis on thoughts, and the use of homework are typical. Throughout the process of therapy, a number of strategies are used to bring about changes in thoughts, behaviors, and feelings. Some of these are discussed next.

## Therapeutic Techniques

A wide variety of cognitive techniques are used in helping clients achieve their goals. Some of the techniques focus on eliciting and challenging automatic thoughts, others on maladaptive assumptions or ineffective cognitive schemas. The general approach in cognitive therapy is not to interpret automatic thoughts or irrational beliefs, but to examine them through either experimentation or logical analysis. An example of an experiment would be to ask a client who feels that no one will pay attention to her to initiate a conversation with two acquaintances and observe how they attend or fail to

attend to her. An example of questioning a client's logic would be, when the client says "I can never do anything right," to ask "Have you done anything right today?" Cognitive therapists also use techniques to help clients with feelings and behaviors. Some of the techniques used in assisting clients with feelings are described in Chapter 6, and those used to help clients change behaviors are explained in Chapters 8 and 9. About 15 different cognitive therapy techniques are described by Freeman (1987), Dattilio and Freeman (1992), Freeman et al. (1990), and J. S. Beck (1995). *The New Handbook of Cognitive Therapy Techniques* (McMullin, 2000) describes over 35 different techniques. This section explains eight common strategies for helping clients change unhelpful thought patterns.

**Understanding idiosyncratic meaning.** Different words can have different meanings for people, depending on their automatic thoughts and cognitive schemas. Often it is not enough for therapists to assume that they know what the client means by certain words. For example, depressed people are often likely to use vague words such as *upset*, *loser*, *depressed*, or *suicidal*. Questioning the client helps both therapist and client to understand the client's thinking process.

**Client:** I'm a real loser. Everything I do shows that I'm a real loser.

**Therapist:** You say that you're a loser. What does it mean to be a loser?

**Client:** To never get what you want, to lose at everything.

**Therapist:** What is it that you lose at?

**Client:** Well, I don't exactly lose at very much.

**Therapist:** Then perhaps you can tell me what you do lose at, because I'm having difficulty understanding how you are a loser.

**Challenging absolutes.** Clients often present their distress through making extreme statements such as "Everyone at work is smarter than I am." Such statements use words like *everyone*, *always*, *never*, *no one*, and *all the time*. Often it is helpful for the therapist to question or challenge the absolute statement so that the client can present it more accurately, as in the following example:

**Client:** Everyone at work is smarter than me.

**Therapist:** Everyone? Every single person at work is smarter than you?

**Client:** Well, maybe not. There are a lot of people at work I don't know well at all. But my boss seems smarter; she seems to really know what's going on.

**Therapist:** Notice how we went from everyone at work being smarter than you to just your boss.

**Client:** I guess it is just my boss. She's had a lot of experience in my field and seems to know just what to do.

**Reattribution.** Clients may attribute responsibility for situations or events to themselves when they have little responsibility for the event. By placing blame on themselves, clients can feel more guilty or depressed. Using the technique of reattribution, therapists help clients fairly distribute responsibility for an event, as in this example:

**Client:** If it hadn't been for me, my girlfriend wouldn't have left me.

**Therapist:** Often when there is a problem in a relationship, both people contribute to it. Let's see if it is all your fault, or if Beatrice may also have played a role in this.

**Labeling of distortions.** Previously, several cognitive distortions such as all-or-nothing thinking, overgeneralization, and selective abstraction were described. Labeling such distortions can be helpful to clients in categorizing automatic thoughts that interfere with their reasoning. For example, a client who believes that her mother always criticizes her might be asked to question whether this is a distortion and whether she is "overgeneralizing" about her mother's behavior.

**Decatastrophizing.** Clients may be very afraid of an outcome that is unlikely to happen. A technique that often works with this fear is the "what-if" technique. It is particularly appropriate when clients overreact to a possible outcome, as in this case:

**Client:** If I don't make dean's list this semester, things will be over for me. I'll be a mess; I'll never get into law school.

**Therapist:** And if you don't make dean's list, what would happen?

**Client:** Well, it would be terrible, I don't know what I would do.

**Therapist:** Well, what would happen if you didn't make dean's list?

**Client:** I guess it would depend on what my grades would be. There's a big difference between getting all B's and not making dean's list and getting all C's.

**Therapist:** And if you got all B's?

**Client:** I guess it wouldn't be so bad, I could do better the next semester.

**Therapist:** And if you got all C's?

**Client:** That's really not likely, I'm doing much better in my classes. It might hurt my chances for law school, but I might be able to recover.

**Challenging all-or-nothing thinking.** Sometimes clients describe things as all or nothing or as all black or all white. In the previous example, the client is not only catastrophizing about grades but also dichotomizing the idea of making or not making the dean's list. Rather than accept the idea of dean's list versus not dean's list, the therapist uses a process called *scaling*, which turns a dichotomy into a continuum. Thus, grades are seen as varying in degree; the client will respond differently to the possibility of getting a 3.0 rather than a 3.25 than to the possibility of dean's list or not dean's list.

**Listing advantages and disadvantages.** Sometimes it is helpful for patients to write down the advantages and disadvantages of their particular beliefs or behaviors. For example, a student can write down the advantages of maintaining the belief "I must make dean's list" and the disadvantages of such a belief. This approach is somewhat similar to scaling, as listing the advantages and disadvantages of a belief helps individuals move away from an all-or-none position.

**Cognitive rehearsal.** Use of imagination in dealing with upcoming events can be helpful. A woman might have an image of talking to her boss, asking for a raise, and then being told, “How dare you even talk to me about this subject?” This destructive image can be replaced through cognitive rehearsal. The woman can imagine herself talking to her boss and having a successful interview in which the boss listens to her request. The cognitive rehearsal can be done so that the woman presents her request in an appropriate way, with the boss not granting the request in one instance and the boss granting the request in another. The therapist asks her to imagine the interview with the boss and then asks the patient questions about the imagined interview.

Other useful cognitive strategies follow a similar pattern. They question the client’s cognitive schemas and automatic thoughts. In addition to cognitive techniques, cognitive therapists may use behavioral techniques such as activity scheduling, behavioral rehearsal, social-skills training, bibliotherapy, assertiveness training, and relaxation training (discussed in other chapters). In the practice of psychotherapy, many of these techniques are used at different times in the therapeutic process to bring about change in cognitions, feelings, and behavior.

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## COGNITIVE TREATMENT OF PSYCHOLOGICAL DISORDERS

Cognitive therapists have probably developed explanations and specific treatments for more psychological disorders than has any other therapeutic approach. Particularly for depression and general anxiety, two disorders described here, they have provided a detailed approach to treatment and have been able to test these approaches through the application of outcome research. Other disorders discussed here include obsessional thinking and substance abuse. Because the type of cognitive distortions that patients experience can vary within each disorder, and because there are many cognitive techniques, the examples given here are not meant to represent a universal application of cognitive therapy to each of these four disorders. Additionally, the treatment descriptions highlight only major approaches to cognitive therapy with these problems, as a full account goes beyond the scope of this book.

### Depression

Beck’s (1967) initial application of cognitive therapy was to depression. More writing and research have been devoted to depression in cognitive therapy than to any other disorder. Clark and Beck (1999) have thoroughly described the rationale for cognitive therapy as treatment for depression in *Scientific Foundations of Cognitive Theory and Therapy of Depression*. Three practical applications to the treatment of depression make thorough use of Beck’s treatment approach: *Cognitive-Behavioral Treatment of Depression* (Klosko & Sanderson, 1999), *Essential Components of Cognitive-Behavior Therapy for Depression* (Persons, Davidson, & Tompkins, 2001), and *Cognitive Therapy for Bipolar Disorders* (Lam, Jones, Hayward, & Bright, 1999). Many conceptualizations of depression include the cognitive triad, which provides a framework for the application of cognitive and other strategies. The term *cognitive triad* refers to the negative view that depressed people have about themselves, their world, and their futures. In terms

of self-perception, depressed people see themselves as worthless, lonely, and inadequate. In a similar way, they view their world as one that makes difficult demands and presents obstacles that keep them from meeting their goals. When they look at the future, depressed people see a dismal view; their problems can get only worse, and they will not be successful. With such perceptions, depressed people are likely to be indecisive, hopeless, tired, and apathetic. Their cognitive distortions may include those discussed earlier: all-or-nothing thinking, catastrophizing, overgeneralization, selective abstraction, mind reading, negative prediction, personalization, labeling and mislabeling, and magnification or minimization.

Many of the cognitive distortions described in this chapter, as well as common cognitive therapy techniques, are used in the course of treating depression. In this section, I describe treatment strategies suggested by Liese and Larson (1995) in their detailed approach to the treatment of depression with Paul. In their approach, they establish a collaborative therapeutic relationship leading to conceptualization of Paul's problems, which includes assessment of his basic beliefs and cognitive schemas. They then educate Paul by presenting important information that is relevant to his basic beliefs. Additionally, they apply the Socratic method, the three-question technique, and the Daily (Dysfunctional) Thought Record to help Paul make changes in thoughts and behaviors.

Conceptualizing Paul's problems includes a psychiatric diagnosis, determination of his current problems, a history of his childhood development, and a profile of his basic beliefs and automatic thoughts. Paul is a 38-year-old lawyer who recently found out he has AIDS. He had been sad, had difficulties sleeping and concentrating, and had been extremely anxious. According to Liese and Larson (1995), he was experiencing a major depressive episode of moderate severity. An only child, Paul was expected to perform well in school and did so. As a result of relationships with parents and at school, Paul developed two significant beliefs about himself: "I am lovable only when I please others" and "I am adequate only when others love me" (p. 18).

Paul sought love and approval through promiscuous sexual relationships with other men. This behavior reflected his attempts to "avoid feeling lonely" (p. 18). When he entered therapy, his behavior was reflected in certain basic beliefs.

"Now, I'm really unlovable and defective."

"I have disappointed everyone who matters to me."

"I deserve AIDS because of my behavior." (p. 18)

The therapist shared his diagnosis with Paul. Sensitive to Paul's sadness and fear, the therapist was empathic with Paul's feelings. However, Paul was surprised to discover the high degree of structure in cognitive therapy. During his second session Paul commented that the structure made therapy seem "kind of impersonal." With a great deal of encouragement from the therapist, Paul was able to admit (to the therapist): "You seem more concerned about problem solving than you are about me as a person." They discussed this belief, and Paul learned from his therapist that such beliefs reflect mind reading. Paul eventually realized from his therapist's spontaneous warmth and empathy that his therapist genuinely cared about him. He further learned that therapeutic structure would contribute substantially to defining problems and resolving them (p. 19).

To help Paul with his depression, the therapist used the Socratic method (guided discovery). In this way Paul could realize that his life was not over.

**Ther:** How are you feeling today? (open question)

**Paul:** Pretty depressed.

**Ther:** You seem depressed. (reflection) What have you been thinking about? (open question)

**Paul:** My life seems wasted at this point.

**Ther:** What do you mean by “wasted”? (open question)

**Paul:** It seems like nothing matters anymore.

**Ther:** “Nothing.” (reflection) . . . (long pause) Can you think of anything that does matter? (open question)

**Paul:** (long pause) Curt is important, I guess.

**Ther:** You only “guess”? (reflection/question)

**Paul:** Okay, Curt really is important.

**Ther:** What else is important to you? (open question)

**Paul:** I guess my friends are still important to me.

**Ther:** What makes your friends important to you? (open question)

**Paul:** They really seem to care about me.

**Ther:** When you consider your importance to Curt and your friends, what thoughts do you have? (open question)

**Paul:** Well, I guess my life isn’t completely wasted.

**Ther:** And how do you feel when you think your life is not wasted? (open question)

**Paul:** Somewhat less upset.

In this dialogue, the therapist has begun to help Paul feel emotional relief simply by guiding him to think about his important relationships with Curt and his friends. The Socratic method facilitates Paul’s ability to discover his *own* positive thoughts, resources, and strengths rather than having the therapist advise or dispute maladaptive thoughts (pp. 21–22).

To deal further with the issue of feeling that his life is wasted, the therapist uses the three-question technique.

**Ther:** You told me a few minutes ago that your life was wasted. (reflection) What is your *evidence* for this belief? (question #1)

**Paul:** I don’t have any evidence. I just feel that way.

**Ther:** You “just feel that way.” (reflection) *How else* could you look at the situation? (question #2)

**Paul:** I guess my life isn’t wasted if I’m still important to Curt.

**Ther:** If, in fact, you weren’t important to Curt, what would the *implications* be? (question #3)

**Paul:** I guess it might be tolerable if my friends didn’t abandon me.

In this very brief interaction, Paul's therapist helps him to become more objective about his own worth. In fact, when Paul realizes that his life has some meaning, he begins to experience emotional relief (p. 23).

Paul's therapist had him complete at least two DTRs daily when Paul first began therapy. At that time Paul had reported feeling extremely depressed. Hence, "entering counseling" was written in the *situation* column and "depression" was written in the *emotions* column. Paul revealed that his *automatic thoughts* about counseling were: "It's hopeless. I won't benefit from this." These were written in the automatic thoughts column. The therapist helped Paul, using the Socratic method, to identify *rational responses* to his belief "It's hopeless." With prompting, Paul proposed the alternative, more adaptive thoughts: "In fact, I can't say for sure that there is no hope." "Maybe there is some hope for me." (p. 24)<sup>3</sup>

Additionally, Paul's therapist used homework that included filling out a weekly activity schedule. Through this cognitive therapy approach, Paul was able to become less depressed and find more meaning in his life. Implicit in this example is the attention to a detailed assessment of negative automatic thoughts. A great variety of cognitive strategies are used, many more than are presented in this chapter, for changing the depressive thoughts and behaviors of clients (Klosko & Sanderson, 1999; Parsons, Davidson, & Tompkins, 2001).

## General Anxiety Disorder

In applying the cognitive triad to anxiety, Beck, Emery, and Greenberg (1985) discuss the role of threat. Individuals may view the world as dangerous, where catastrophes may occur or people may hurt them. This threat can be applied to the self, where individuals are afraid to assert themselves or to try to overcome a threat or danger. This outlook carries over into their view of the future, in which they believe that they will be unable to deal with events that they perceive will be dangerous. Anxious people are likely to perceive an event as risky and their abilities as minimal.

Freeman and Simon (1989) identify the significant cognitive schema of anxiety as that of hypervigilance. Individuals with this schema usually have a history of being alert to their surroundings. Some may be very aware of who is sick, the weather, road conditions, or the looks on persons' faces. Less anxious people may perceive such environmental factors but do not have automatic thoughts that indicate that these situations are threats to them. They have an accurate assessment of risk and danger, not a hypervigilant one.

In assessing the cognitive distortions of anxious individuals, Freeman et al. (1990) note that catastrophizing, personalization, magnification and minimization, selective abstraction, arbitrary inference, and overgeneralization are common. When anxious clients catastrophize, they dwell on extreme potential negative consequences. They may assume that if something harmful could potentially happen, there is a great likelihood that it will. In the following example, the client's cognitive distortion of catastrophizing is countered by the therapeutic intervention of decatastrophizing. By using the Socratic method, the therapist is able to have the client describe her fears in detail and then counters the fears by asking, "What is the worst that could happen?"

Amy came into treatment for her fears of eating and drinking in public that were severely limiting her life. As she was planning to go out for coffee with some friends (including Sarah, a woman she did not know well), she had been able to identify the thought, “What if I get upset and really start shaking?” She and the therapist explored the likelihood of that happening and concluded that it was possible (because that had happened before) but not very likely (because she had been quite anxious in a number of situations but had not had a severe shaking episode in a long time). The therapist then moved on to explore the worst possible scenario by asking, “Well, let’s just say that you did get so upset that you shook harder than you ever have before. What’s the worst that could happen?” Amy replied, “Sarah might notice and ask what’s the matter with me.” The therapist then asked, “And if she did notice and ask you, what’s the worst that would happen next?” This time Amy thought for a second and answered, “Well, I’d be terribly embarrassed, and Sarah would probably think I was weird.” Once more, the therapist asked, “And what’s the worst that could happen then?” After thinking some more, Amy replied, “Well, Sarah might not want to have any more to do with me, but the other people they are my friends and probably would understand.” Finally, the therapist asked, “And if that did happen?” Amy concluded, “I’d feel embarrassed, but I do have plenty of good friends, so I’d live without Sarah as a friend. Besides, if she’s that narrow minded, who needs her anyway?” (Freeman et al., 1990, p. 144)<sup>4</sup>

In this example, negative thoughts are identified and modified through questioning. Sometimes therapists may use imagery or actual behavior to challenge fears. Often cognitive therapists use the behavioral technique of relaxation training, together with other cognitive methods, to reduce individuals’ stress or anxiety.

## Obsessive Disorder

Chapter 8 describes a cognitive behavioral approach, response prevention and exposure, for treating obsessive-compulsive disorders that combine obsessions with compulsive rituals (such as checking a car door 20 times to see if it is locked). Most individuals with obsessive thoughts (those that clients continually worry about) tend to seek out certainty in situations that others usually believe to be safe. For example, a physically healthy person who obsesses may worry repeatedly about getting cancer, whereas other individuals who do not obsess would not worry continually about a low-risk event but rather address the issue by having a physical examination once every year or two.

In describing automatic thoughts that are typical of individuals with obsessive-compulsive problems, Beck, Freeman, and Associates (1990) list a number of typical automatic thoughts.

1. “What if I forget to pack something?”
2. “I better do this again to be sure I got it right.”
3. “I should keep this old lamp because I might need it someday.”
4. “I have to do this myself or it won’t be done correctly” (p. 314).

Underlying these automatic thoughts are assumptions that Beck et al. (1990) believe that individuals who have obsessive thoughts make about themselves and their world.

- “There are right and wrong behaviors, decisions, and emotions” (p. 314).  
 “To make a mistake is to be deserving of criticism” (p. 315).  
 “I must be perfectly in control of my environment as well as of myself,” “Loss of control is intolerable,” and “Loss of control is dangerous” (p. 315).  
 “If something is or may be dangerous, one must be terribly upset by it” (p. 315).  
 “One is powerful enough to initiate or prevent the occurrence of catastrophes by magical rituals or obsessional ruminations” (p. 316).

For people with obsessions, guilt often follows from not doing what one should or must. For such individuals, reassurance is never sufficient and alleviates anxiety only for the moment, not over the long term. Although there are several methods for dealing with obsessive thinking, two specific examples characterize a cognitive approach: habituation training and the thought-action fusion model. Both of these approaches attempt to counter the avoidance that individuals use in trying to deal with obsessional thoughts.

Habituation training elicits obsessional thoughts over and over again in a predictable way to reduce anxiety. Following a detailed assessment of the problem, the client and therapist work on ways to get used to thoughts without feeling that anything needs to be done about them. What emerges is a method that involves having the patient deliberately evoke the thought, write thoughts down repeatedly, and listen to a tape of the thoughts and the patient’s voice (Rush & Beck, 2000; Salkovskis & Kirk, 1989).

Another approach to helping those with obsessive thoughts is a model that examines the fusion of thoughts and actions. Wells (1997) has continued the work of Rachman (1997) and Wells and Matthews (1994) that describes how individuals with obsessive thoughts tend to equate them with actions. For example, a person who has a thought about harming a child may think that he is going to harm the child. This fusion of thought and actions can also be applied to past actions. If I think I have done something bad in the past, I probably did it. Thus, if I felt that I harmed a child in the past, I may feel that I did it. Needleman (1999) gives an example of Carlos, who believed he may have hit someone with his car when he did not. The therapist created an experiment in which Carlos held a hammer over his therapist’s thumb and repeated the thought “I’m going to smash her thumb as hard as I can” (p. 221). Reluctantly, Carlos agreed to it and was able to separate an intrusive thought from an intention.

Wells (1997) makes several suggestions about how to conceptualize and help individuals who fuse their thoughts and feelings. The basic goal of this therapy is to help the patient see the thoughts as irrelevant for further action and to develop a detached acceptance of intrusive thoughts. In gathering data about these thoughts, Wells has developed a modified version of the Dysfunctional Thought Record for obsessive-compulsive disorder.

Wells describes several methods for defusing thoughts from actions and events. One of the first steps is to help the patient increase his awareness of when thought-action fusion is taking place. He uses a similar approach in helping patients defuse thoughts and events. In the following, he uses a Socratic dialogue to help a man distinguish between thoughts and events at work.

**T:** How long have you been checking the power sockets at work?

**P:** About three years.

- T:** Have you ever discovered that you forgot to switch them off?
- P:** No. I go around systematically and switch them off. But that doesn't stop me driving back to work to check.
- T:** So even though you have many experiences telling you that your doubting thoughts are not true, you still believe that they are. What makes you believe that?
- P:** I don't know. Perhaps I haven't switched them off properly.
- T:** When you check is there any evidence of that?
- P:** No.
- T:** Yet you continue to check and continue to have a problem. So how helpful is your checking in overcoming your problem?
- P:** Obviously it's not helping at all.
- T:** So why don't you stop checking?
- P:** I'd be too uncomfortable. It would ruin my weekend.
- T:** What do you mean by uncomfortable?
- P:** I'd be dwelling on the possibility that I'd not turn things off.
- T:** So you'd still be responding as if your thoughts were true. What if you responded to your thoughts differently, could that help?
- P:** Well, I already tell myself that it's stupid to think these things.
- T:** Does that stop you dwelling on the thought?
- P:** No. I go through my switching off routine in my head to see if I can remember all of it.
- T:** So you're still acting as if your thought is true. It sounds as if it might cause its own problems.
- P:** Sometimes it makes me feel better, but if I can't clearly remember switching off some of the appliances, it means I'll feel worse and I'll end up checking.
- T:** So how useful is your behavioural or mental checking in the long run?
- P:** I can see it probably doesn't help. But I'd feel worse if I didn't check.
- T:** OK. We can explore that possibility in a minute. But I think we should do something about your strategies for dealing with your thoughts. It sounds as if your checking may be generating more doubts and keeping your problem going. (Wells, 1997, pp. 254–255)<sup>5</sup>

Wells uses several other cognitive strategies to help patients defuse their thoughts from actions and events. He also makes use of the exposure and response prevention strategies described on page 000 in Chapter 8. The approaches of Salkovskis and Kirk (1989) and Wells (1997) are not the only models. Two others that are speculative and developing from research on cognitive therapy are described on page 000.

### Substance Abuse

The application of cognitive therapy to substance abuse is thorough and complex, described in detail in *Cognitive Therapy of Substance Abuse* (Beck, Wright, Newman, &

Liese, 1993). Liese and colleagues (Liese & Franz, 1996; Liese & Beck, 2000) discuss advances in the cognitive treatment of substance abuse. Although the treatment of drug-abusing patients follows a cognitive model that is somewhat similar to the treatment of other disorders, there are significant differences. The therapeutic relationship may be difficult because patients may not enter treatment voluntarily, may be involved in criminal activities, may have negative attitudes about therapy, and may be unwilling to be honest about their drug usage. When setting goals, therapists focus not only on being drug free but also on how this will solve other problems, such as financial and work problems. Particular issues unique to substance abuse are those of dealing with cravings due to withdrawal symptoms and a lack of the pleasure that was previously provided by the drug. Of importance is the focus on the individual's belief system, which is described in more detail here.

Those who abuse drugs tend to hold three basic types of beliefs: anticipatory, relief oriented, and permissive (Beck et al., 1993). Anticipatory beliefs refer to an expectation of reinforcement, such as "When I see Andy tonight, we'll get high. Great!" Relief-oriented beliefs often refer to the removal of symptoms due to psychological or physiological withdrawal. Permissive beliefs are those that refer to the idea that it is all right to use drugs. Examples include "I can use drugs, I won't get addicted" and "It's OK to use . . . everybody else does." These permissive beliefs are self-deceiving and can be considered rationalizations or excuses. Permissive beliefs are especially common. McMullin (2000) lists several, along with therapeutic comments that can be used to counter client statements. "A couple of drinks are good for me" (p. 364) can be countered by "when was the last time you had two drinks of anything?" (p. 365). The major focus of cognitive therapy is to challenge and change a variety of beliefs.

To change the belief system of drug abusers, Beck et al. (1993) suggest six methods: assessing beliefs, orienting the patient to the cognitive therapy model, examining and testing addictive beliefs, developing control beliefs, practicing activation of these new beliefs, and assigning homework (p. 171). Assessment of such beliefs comes from questions such as "How do you explain . . .?" and "What are you thinking about?" (p. 171). To further assess beliefs, Beck and his colleagues have developed drug-related questionnaires, such as the Craving Beliefs Questionnaire, Beliefs About Substance Abuse, and Automatic Thoughts About Substance Abuse. After a thorough assessment of beliefs, the patient can then be oriented to the specific cognitive model of addiction.

Belief systems related to drug abuse tend to become firm and entrenched. Such beliefs, including "Marijuana is great," "You can't get off heroin," and "Nothing beats a cocaine high," can be examined and tested by questions such as "What is your evidence for that belief?", "How do you know that your belief is true?", and "Where did you learn that?" (Beck et al., 1993, p. 177). To develop a system of control beliefs, or new beliefs, to replace previous dysfunctional ones, therapists use the Socratic method, as in this example dealing with cocaine use:

**Therapist:** Bill, you now seem less dead set in believing that nothing is as much fun as getting high.

**Bill:** I'm not sure what to believe now.

**Therapist:** What do you mean?

**Bill:** Well, I still think that getting high with my friends was lots of fun, but maybe it wasn't the perfect high I made it out to be.

**Therapist:** Bill, what else could you have done with your friends that would have been fun?

**Bill:** Well, I don't know about these guys, but with other friends in the past I could have gone to a baseball game, or played racquetball, or done something like sports or something.

**Therapist:** What else?

**Bill:** I guess there are lots of things . . . but none seems as exciting as doing cocaine.

**Therapist:** Let's try to think of some more things. What gave you the biggest thrill before you began using cocaine?

**Bill:** Well, I was an adventurous guy. When I was much younger I would go camping and hiking and rock climbing, but I'm in no shape for that now.

**Therapist:** What do you mean when you say "I am in no shape for that"?

**Bill:** I guess I'm just skeptical that I would enjoy that kind of thing anymore. It's just been so long since I last did it.

**Therapist:** What would it take for you to try doing those things again?

**Bill:** I guess I'd just have to do them.

**Therapist:** What were some of the feelings you had in the past when you would go camping or hiking or climbing?

**Bill:** I felt great . . . really alive!

**Therapist:** How did that feeling compare to the cocaine high?

**Bill:** (pause) . . . I guess, in some ways it was better.

**Therapist:** What do you mean?

**Bill:** Well, I really earned the high I got from those activities. There were no short cuts then. It was a super feeling.

**Therapist:** So perhaps you now have a control belief to replace the old addictive belief. "I can experience a super high without using cocaine."

**Bill:** Yes, I just need to remember that thought. (Beck et al., 1993, pp. 179–180)<sup>6</sup>

After control beliefs have been developed, they then must be practiced. Sometimes therapists use flash cards to reinforce the beliefs, including messages such as "Getting wasted can get me busted" or "When I smoke crack, I have no control of my life." Clients fantasize a craving for the drug and then use control beliefs to counter the craving. Accompanying the practice in using control beliefs within the session is that of assigning homework to be done outside therapy. Control beliefs are practiced in high-risk situations, such as being around friends who use the drug.

Although changing the belief system is essential in cognitive therapy of drug abuse, other issues are also addressed. Therapists help their clients deal with concerns such as reactions of family members or financial issues. Stress from work or from friends who abuse drugs can also add to the patient's problems. Additionally, when working with substance abuse, therapists teach clients methods for preventing relapse. Throughout the process of drug treatment, Socratic methods are used frequently, as are other techniques that help drug abusers change distorted beliefs.

Although this section has focused on disorders of depression, generalized anxiety, obsessive thinking, and substance abuse, cognitive therapy has been applied to many other concerns. Some examples are agoraphobia, posttraumatic stress disorder, grief, bulimia and anorexia, obesity, narcissism, borderline personality disorder, schizophrenia, multiple personality, and chronic pain. Books and articles describe each of these disorders and give examples of common cognitive distortions likely to be present as well as specific cognitive techniques.

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## BRIEF COGNITIVE THERAPY

For many disorders, such as depression and anxiety, cognitive therapy tends to be brief, usually between 12 and 20 sessions. Sometimes therapists see patients twice a week for the first month and then weekly for the next several months. A number of factors influence the length of psychotherapy, such as the client's willingness to do homework, the range and depth of problems, and how long the client has had the problem. For narcissistic, borderline, and other personality disorders, treatment often takes between 18 and 30 months, with meetings two or three times a week during the beginning of therapy. Other factors, such as therapists' style and experience, and potential for relapse may also affect the length of cognitive therapy.

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## CURRENT TRENDS

A significant trend in cognitive psychotherapy is constructivism. Cognitive therapy (Alford & Beck, 1997; Rosen, 1993) shows how clients are helped to look at their problems from many different points of view and think about what has happened to them from different perspectives. The notion of cognitive distortions implies that the therapist has a perception of reality that she shares with clients to help them change their ineffective views of reality. Because cognitive therapy is collaborative, both the client's and therapist's perception of reality is influenced by each other's perceptions. However, the development of very specific treatment manuals for different psychological disorders suggests that cognitive therapists have highly developed views of problems patients bring to therapy, which would be in opposition to the openness of a constructivist point of view.

Several recent books, many of them treatment manuals, describe how cognitive therapy can be applied to specific populations and to disorders. Some have covered the application of cognitive therapy to children, for example, *Treatments that Work with Children* (Christophersen & Mortweet, 2001). Another book describes the application of cognitive therapy to individuals with physical disabilities: *Cognitive-Behavioral Therapy with Persons with Disabilities* (Radnitz, 2000). Other books cover the application of cognitive therapy to psychological disorders. Because of their specificity, recommending specific interviewing strategies, protocols, and questionnaires, these serve as treatment manuals. *Cognitive-Behavioral Therapy for Bipolar Disorder* (Lam et al., 1999) and *Bipolar Disorder: A Cognitive Therapy Approach* (Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2001) show specific ways for dealing with the depressive and manic phases of bipolar depression. Cognitive therapy has also been applied to

psychoses, as illustrated by *A Casebook of Cognitive Therapy for Psychoses* (Morrison, 2001). Aaron Beck (2001b) wrote a chapter for that book and has published other recent articles that show applications of cognitive therapy for schizophrenia. Because of the popularity of cognitive therapy and the number of individuals undertaking research studies, more books about applications to specific psychological disorders are likely to be written in the future.

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## USING COGNITIVE THERAPY WITH OTHER THEORIES

Because cognitive therapy has both behavioral and affective components, it draws on other theories, especially behavior therapy and REBT. When using cognitive therapy, many behavioral treatments are incorporated, such as in vivo exposure, positive reinforcement, modeling, relaxation techniques, homework, and graded activities. Cognitive therapy shares with behavior therapy the emphasis on a collaborative relationship with the client and the use of experimentation in trying behavioral and cognitive homework. Additionally, cognitive therapists attend to the feelings and moods of the client, incorporating empathic aspects of person-centered therapy. To further integrate the client's experiential and affective experiences into therapy, Fodor (1987) suggests using Gestalt enactment techniques such as the empty chair or awareness exercises. Also, the Gestalt approach to imagery uses emotional responses as a way of accessing cognitions to provide an overview of beliefs and to help clients be aware of painful affect (Edwards, 1989). By using behavioral and Gestalt methods, cognitive therapists make their therapeutic treatments more flexible and more effective in dealing with the noncognitive aspects of individuals' problems.

Cognitive therapy shares with rational emotive behavior therapy (REBT) many techniques and strategies, but there are some important differences. Whereas REBT challenges irrational beliefs, cognitive therapy helps clients change beliefs into hypotheses they can contest. Another important difference is that cognitive therapy approaches psychological disorders differentially by identifying cognitive schemas and distortions as well as behaviors and feelings that are appropriate to each disorder, whereas REBT focuses on methods to change irrational beliefs themselves regardless of the nature of the psychological disorder. Although they differ as to the philosophical approach to psychological disturbances, both cognitive and REBT practitioners are likely to make use of Socratic and disputational methods in dealing with clients' belief systems.

Originally developed because of Beck's dissatisfactions with psychoanalytic therapy, cognitive therapy uses some psychoanalytic constructs. Both cognitive and psychoanalytic therapies believe that behavior can be influenced by beliefs. However, psychoanalysis emphasizes the importance of unconscious beliefs, whereas cognitive therapy focuses on the conscious belief system. The concept of automatic thoughts in cognitive therapy bears a similarity to the preconscious of psychoanalysis.

Not only do cognitive therapists draw on a variety of other theories in their work but also other theorists have drawn heavily on cognitive therapy. Behavior therapy and cognitive therapy share an emphasis on detailed assessment and experimenting with methods of change. Additionally, Adlerian therapists and rational emotive behavior therapists emphasize Beck's cognitive methods in their approach and make use of many

of the cognitive strategies discussed in this chapter. Also, therapists using other theories may not use detailed cognitive assessment in their work but may examine their clients' cognitive distortions and use cognitive techniques, such as decatastrophizing, to help bring about change. Because cognitive therapy, which was started in the 1960s, has become popular quickly, the integration of it into other therapies is likely to continue.

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## RESEARCH

In recent years there has been great interest in studying the effectiveness of cognitive therapy, particularly in contrast with behavior, psychodynamic, and psychopharmacological treatments. Butler and J. S. Beck (2001) reviewed 14 meta-analyses on cognitive therapy that included 325 studies and 9,138 individuals. The meta-analyses included several psychological disorders and had many findings, the most significant being that cognitive therapy provided help to those who received treatment as contrasted to those who received a placebo or other control condition. Without doubt, the greatest amount of effort has been devoted to research on depression. Several meta-analyses on research into effective methods of treating depression are presented here, as are two studies comparing cognitive therapy with other treatments. Additionally, research on the effectiveness of cognitive therapy as treatment for generalized anxiety and obsessional disorders is described. The review of research in this section is very brief and does not explore the application of cognitive therapy to the many other psychological disorders.

### Research on Depression

Much attention has been given to studying the effectiveness of Beck's cognitive therapeutic approach to depression, as can be seen by several meta-analyses that evaluate it. In a meta-analysis examining 58 investigations, Robinson, Berman, and Neimeyer (1990) found that depressed clients benefited considerably from psychotherapy, with gains comparable to pharmacotherapy. Gloaguen, Cottraux, Cucherat and Blackburn (1998) reviewed 72 studies of adults using randomized clinical trials. They concluded that cognitive therapy helped patients significantly better when compared to waiting-list, antidepressants, and miscellaneous therapies. Cognitive therapies for depression did not produce significantly better results than behavior therapy. Fewer studies have been conducted with adolescents, so conclusions need to be tentative. However, cognitive therapy was found to be superior to wait list, relaxation therapy, and supportive therapy at the conclusion of treatment and in 6- to 12-week follow-ups in 13 studies (Reinecke, Ryan, & DuBois, 1998). DeRubeis and Crits-Christoph (1998) review meta-analyses and large-scale studies on the effectiveness of cognitive therapy that meet stringent criteria for comparing treatments of depression. They find cognitive therapy to be effective, but not necessarily more so than psychopharmacology or psychodynamic or interpersonal approaches.

One of the largest studies to be undertaken in the study of depression has been the National Institute of Mental Health Treatment of Depression Collaborative Research Program (TDCRP) (Elkin, 1994; Elkin, Gibbons, Shea, & Shaw, 1996). The purpose

of this study was to test the comparative effectiveness of cognitive behavior therapy (CBT), interpersonal psychotherapy, pharmacotherapy using imipramine and clinical management, and a pill-placebo and clinical management approach. This study was carried out in three different cities with a random placement of a total of 250 patients into each of the four treatment categories. Each treatment session was videotaped so that the process as well as the outcome of psychotherapy could be measured. Although findings continue to be gathered in this study, some conclusions have been made. Cognitive behavior therapy was not significantly inferior to pharmacotherapy or significantly superior to placebo treatment with minimal support. Also, cognitive therapy seemed to work better for those who were less depressed than for those who were more depressed (pharmacotherapy appeared to be particularly effective for the latter group). In later follow-up there was some support for CBT as being somewhat better than pharmacotherapy in some groups, on certain measures. DeRubeis and Crits-Christoph (1998) point out that the positive effects of cognitive therapy continued beyond a 1-year follow-up, whereas the effectiveness of medication sometimes stopped when patients who had been feeling less depressed discontinued their medication. Started in 1977, the TDCRP was the first large-scale study to involve clinics in several cities (Parloff & Elkin, 1992).

The application of cognitive therapy to depression continues to be a widely investigated topic. For example, depressed patients who did assigned psychotherapy homework were found to improve much more than patients who did little or no homework (Burns & Spangler, 2000). Interestingly, severity of depression did not seem to be a factor in whether or not patients did homework. What else might be responsible for improvement in cognitive therapy? Tang and DeRubeis (1999) found that gains in the treatment of cognitive therapy for depression were often the result of significant changes in thinking about problems related to depression that occurred in the previous session. Studying major depression, Gortner, Gollan, Dobson, and Jacobson (1998) found that those in the cognitive therapy treatment group took longer to relapse than those taking medication, but relapse did occur after 12- and 18-month follow-ups. Another study (Teasdale et al., 2001) suggests that relapse can be reduced by training patients to be intentional rather than automatic in the way they process unwanted thoughts. Rather than change their beliefs, they can label them as “events in the mind.”

### **Research on Generalized Anxiety**

In their review of the effectiveness of cognitive therapy with patients who have symptoms of generalized anxiety disorder, Hollon and Beck (1994) conclude that cognitive therapy is successful in reducing individuals' perception of threat and reducing levels of distress. They report that cognitive therapy has been more effective than behavioral or pharmacological therapy, especially in maintaining therapeutic change over time. One reason that cognitive therapy may be superior to behavioral therapy in working with general anxiety disorders is that there are few specific target behaviors for behavioral therapy to focus on, whereas cognitive therapy can focus on distorted cognitions regarding beliefs related to threat. Their conclusions are basically supported by Gould, Otto, Pollack, and Yap (1997), who found cognitive therapy to be significantly more

effective than waiting-list, placebo, no-treatment control groups or nondirective therapy in a meta-analysis of eight studies on general anxiety disorder. Further insight into differential effectiveness between behavior therapy and cognitive behavior therapy can be seen in a study by Butler, Fennell, Robson, and Gelder (1991). They provided individual treatment lasting between 4 and 12 sessions to 57 patients who met the criteria for generalized anxiety disorder. Those who received behavior therapy were treated with muscle relaxation and, where possible, made a hierarchy of anxious stimuli to which they were exposed *in vivo*. For the cognitive behavior therapy sample, patients kept records of dysfunctional thoughts and developed skills to examine the thoughts and to formulate alternatives to them that could be tested in subsequent homework. The authors report a clear advantage of cognitive behavioral over behavior therapy, because cognitive techniques, more so than behavioral ones, tend to help individuals by dealing with ways of thinking that promote anxiety as well as the consequences of anxiety (the latter is the focus of behavior therapy). Another study with 14 patients with general anxiety disorder found that significant gains were made in comparison to 12 patients in a delayed treatment condition (Ludouceur et al., 2000). The treatment focused on helping patients tolerate uncertainty, challenge erroneous beliefs about worry, and improve their approach to solving problems that contributed to anxiety.

### **Research on Obsessional Disorders**

As described in Chapter 8, response prevention and exposure have been shown to be effective for dealing with obsessive-compulsive disorders. Abramowitz (1997), reviewing studies that compared cognitive techniques to response prevention and exposure, found cognitive techniques to be at least as effective as exposure. These approaches overlap somewhat, so it is difficult to separate them. When there are obsessions or ruminations but no compulsive or ritualistic behavior, the appropriate treatment method is less clear. In comparing cognitive therapy and behavior therapy in the treatments of obsessive disorders, Emmelkamp and Beens (1991) found little difference between exposure therapy, self-statement training (cognitive therapy), or rational emotive behavior therapy. Compared with other psychological disorders, such as depression and generalized anxiety disorder, there is relatively little research into effective methods for changing obsessive thinking. Described next is an exploratory study that uses several single-subject studies to make recommendations for further research and therapy.

In treating obsessive ruminations, Salkovskis and Westbrook (1989) suggest that obsessions can be divided into obsessional thoughts and cognitive rituals. Using a method somewhat similar to exposure and response prevention, they suggest methods for preventing clients from engaging in cognitive rituals. Following up on a preliminary study by Salkovskis and Westbrook, Freeston et al. (1997) studied 29 patients with obsessive thoughts but not compulsive rituals. They used procedures similar to those of Salkovskis and Westbrook, finding that the treatment was effective in patients after a 6-month follow-up. A manual (McGinn & Sanderson, 1999) combines the work on exposure/ritual prevention and Beck and Salkovskis's approach to cognitive restructuring in treating obsessive-compulsive symptoms.

New procedures for dealing with obsessions continue to be developed and studied. Rachman (1997) suggests a cognitive approach in which patients modify their catastrophic misinterpretations of the significance of intrusive obsessive thoughts. Jones and Menzies (1997a, 1997b) have done preliminary work using Danger Ideation Reduction Therapy (DIRT), which is designed to help patients change their fears of the danger of their obsessional thoughts. Treating five patients for compulsive washing who did not respond to exposure and ritual prevention and medication, Krochmalik, Jones, and Menzies (2001) found that four responded to DIRT.

Although I have given examples of research studies evaluating the effectiveness of cognitive therapy with depression, generalized anxiety disorder, and obsessive thinking, cognitive therapy has been evaluated with many other disorders. Particularly, much research has recently been done on the effectiveness of cognitive therapy in treating individuals with panic disorder, agoraphobia, and posttraumatic stress (Butler & Beck, 2001). Another major focus of cognitive therapy has been treatment for drug and alcohol abuse and cigarette smoking. Severe disorders such as schizophrenia and personality disorders have also been the subject of research, but less extensively than other psychological concerns. Other research areas include evaluating the effectiveness of cognitive therapy with children, couples, and families.

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## **GENDER ISSUES**

In addressing the application of cognitive therapy to women, Davis and Padesky (1989) and Dunlap (1997) describe how gender issues can be incorporated in dealing with women's concerns. Similarly, Bem's (1981) gender schema theory can be used to comprehend how gender schema interact with other schemas in understanding psychological problems. In their analysis of cognitive distortions that are common to women, Davis and Padesky (1989) describe issues related to valuing oneself, feeling skilled, and feeling responsible in relationships, concerns that may occur in issues of body image, living alone, relationships with partners, parenting roles, work issues, and victimization. For Davis and Padesky the advantage of cognitive therapy is that it teaches clients to help themselves and to take responsibility for recognizing negative self-schemas that interfere with being autonomous and powerful.

With regard to treating women who are depressed, Piasecki and Hollon (1987) and Dunlap (1997) describe the challenge of using cognitive therapy to help women dispute their thoughts and beliefs while at the same time recognizing the value of their own views. Because cognitive therapy is active and structured, therapists need to be careful not to take too much power or responsibility in the therapeutic contract. Collaboration is particularly important with clients who may feel that it is the therapist's role to tell them what to do, thus ascribing power to the therapist. When working with depressed female clients, Piasecki and Hollon (1987) caution that the therapist must not only help change distorted cognitions but also support client beliefs and values, thus empowering the client. For example, rather than reading through diaries or Dysfunctional Thought Records, the therapist may have the client discuss her observations about her experience regarding her thoughts and her suggestions about how to proceed.

The therapist can then collaborate with the client to make planned changes in thoughts and behaviors.

Cognitive therapy has also been applied to homosexual men and women (Safren & Rogers, 2001) who are dealing with issues of “coming out” (who to tell about their homosexuality, how to tell, and when to tell). In describing a cognitive therapeutic approach to gay men, Kuehlwein (1992) suggests that it is important to help gay men learn more about their sexual orientation and the assumptions they have made about sexuality and sexual roles. Books about sexuality and the coming-out process can be particularly helpful to gay men who are dealing with coming out to others to learn about the gay subculture and to integrate their own beliefs about sexuality. Because there is much misinformation about homosexuality and potential shame about being homosexual, the therapeutic process proceeds gradually, with the client taking responsibility for whom, when, and how to tell about his homosexuality. Often the client and therapist role-play how the client may “come out” to someone, so the client can have control in important areas in his life. Coming-out issues for women can be handled in similar ways (Safren & Rogers, 2001).

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## MULTICULTURAL ISSUES

Just as gender values and beliefs can be seen in cognitive therapy as gender schemas, so can cultural values and beliefs be viewed as cultural schemas. Because cognitive therapists emphasize a collaborative relationship with their clients, they are likely to be able to ascertain values and beliefs that interfere with effective psychological functioning. Such beliefs can affect how patients perceive therapy and the therapist. For example, Australian clients in a drug abuse program may be more challenging and confrontive to a therapist than those in treatment in the United States (McMullin, 2000). Also, cognitive therapy focuses not only on the belief system but also on behaviors and feelings, providing a broad framework to deal with multicultural issues. Such an approach often counteracts the stigma of mental illness that people who are not familiar with the culture of psychotherapy may possess. For many people, the active approach of cognitive therapy in which suggestions can be given during the first session may be quite attractive.

In their writings, cognitive therapists have focused more on treatment of specific psychological disorders and research on the effectiveness of treatment than they have on cultural issues. Some literature exists on psychotherapeutic approaches with different minority groups. Cognitive therapy groups lasting for 32 sessions have been led by probation officers for urban 16- to 20-year-old African American and Latino men on probation (Goodman, Getzel, & Ford, 1996). For depressed adolescents in Puerto Rico, both cognitive therapy and Klerman’s interpersonal process therapy (Chapter 14) were more successful in reducing depressive symptoms than a waiting-list control group (Rossello & Bernal, 1999). The researchers note that both treatments were changed slightly to fit with Puerto Rican cultural values. However, interpersonal process therapy seemed to fit the adolescents’ cultural values better than cognitive therapy, as the former brought about changes in self-concept and adaption whereas cognitive therapy did not. In Malaysia, cognitive therapy is reported to be compatible

with religions and values of that country and particularly helpful in treating depressed and anxious patients (Varma & Zain-Ashar, 1996). Tehrani and Muhammad (1996) report that it fits with Islamic principles and has been effective in working with a prison population. As cognitive therapy's popularity spreads, so does its application to individuals of different cultures.

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## GROUP THERAPY

In cognitive group therapy, therapeutic change comes not as a result of insights that arise from group interaction but as a result of clients making use of change strategies that are consistent with the cognitive model. White (2000b) uses this description to explain the cognitive approach:

To gain a better understanding of yourselves, we want to be able to track your ongoing thoughts, feelings, behaviors. This is what's called using the cognitive model. The more you are able to recognize these immediate reactions on your part, your experience will probably make more sense to you and you'll be able to determine where you want to make changes. (p. 4)

The cognitive approach to each group session tends to center on specific, structured, and problem-oriented changes. In keeping with this model, it would be appropriate before each session to use a measure of change, such as the Beck Depression Inventory, to monitor alternatives and symptoms. Similarly, cognitive interventions in group tend to be specific and, as is shown next, to emphasize practicing cognitions and behaviors. Some cognitive groups may use a specific type of technique, such as problem solving, whereas others may be designed to help people with the same disorder, such as depression.

A method of applying cognitive group therapy to depression is somewhat illustrative of the general approach taken to group therapy by cognitive therapists (White, 2000a). For cognitive group therapy to be successful, group cohesiveness and a task focus must be present. Cohesiveness refers to looking forward to relating to other members, to thinking about them between sessions, and having compassion for the other members. Task focus is one that seeks to resolve problems. To bring about task focus and cohesion, the therapist should model participation and collaboration. This therapist may take a directing role, not in the sense of telling group members what to do but in the sense of organizing the group. Some cognitive group therapists conduct the group standing and write notes on a blackboard. The themes likely to emerge and be dealt with by patients and therapist are loss (loss of energy, loss of appetite, loss of relationships), anger or irritability, and guilt about not meeting responsibilities.

Like individual therapy, group cognitive therapy is frequently structured (White, 2000b). Setting goals is a part of all phases of treatment, which include checking in, setting an agenda, generating adaptive responses, and developing and discussing homework. Checking in is the process of sharing important developments in the past week and reporting on changes in depression. Setting the agenda takes place as the therapist asks the clients what they want to have happen in the available time. Discussion of automatic thoughts is often a part of the process. Generating adaptive thoughts to

counter automatic thoughts is the next part of the process. The therapist discourages giving advice and focuses on generating adaptive thoughts. Homework is then developed to put the discussion into action. This is a general format that White (2000a) uses and adapts to different groups dealing with depression.

Another approach that cognitive therapists may apply as one of several or as the only group technique is problem-solving training (Coché, 1987). In describing a 10- to 12-session problem-solving group with patients in a hospital, Coché lists six steps used to develop effective problem-solving skills. In this approach, a log or diary of the group's progress on each of the steps described is kept. The first step is to bring up problems that members have in their lives, such as "My job is boring. What should I do?" The second step is to clarify the problem and get information from the person who presented the problem. "What is the nature of the job? What is boring about the job? What has changed on the job?" In the third step, group members give possible solutions to the problem, with a record kept of the suggestions. At this point, no criticisms are made of the suggestions. However, in the fourth step, the feasibility of possible solutions is given, with group members determining which suggestions should be tried out. In the fifth step, the patient role-plays the event in the group. For example, the client may play herself, and another client may play her boss, as she discusses with the "boss" how new duties could be added to the job. Sometimes role-playing may not be appropriate, and clients take suggestions and experiment with them outside the group. In the sixth step, clients try out the suggestions they have decided will be most helpful and then report back to the group the results of the experimental activity. In this method, cognitive distortions are confronted by group members, and effective plans are designed for patients with the help of the group members and therapist.

In the cognitive approaches to group described here, several common elements appear. Assessment is specific, with behaviors and cognitions targeted for change. Group members collaborate with the therapist to suggest new ways of thinking about situations and new behaviors to try out. Experimenting with new alternatives to old problems, both within and outside of the group, is an important aspect of group cognitive therapy. Particularly in the beginning of the group meetings, the cognitive therapist takes responsibility for teaching group members new ways to think about their problems. However, cognitive therapy is most often combined with behavioral therapy in group treatment, especially when directed at troubled youth (Feindler & Scalley, 1998; Rose, 1998).

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## SUMMARY

Developed by Aaron Beck from his observations about the impact of patients' belief systems on their psychological functioning, cognitive therapy examines the effect of maladaptive thinking on psychological disorders while at the same time acknowledging the importance of affect and behavior on psychological functioning. As cognitive therapy has developed, it has continued to draw on psychological research into individuals' belief systems and the study of how people process information from their environment. An important aspect of cognitive therapy is the automatic thoughts—that individuals may not be aware of but that make up their belief systems—called *cognitive schemas*.

In his work with patients, Beck identified cognitive distortions that affect individuals' feelings, thoughts, and beliefs, such as all-or-nothing thinking, overgeneralization,

and catastrophizing. To change these beliefs, a thorough assessment is given by attention to distortions inherent in certain thoughts. To further the process of assessment in therapy, Beck and his colleagues have developed a number of instruments for different psychological disorders that assess relevant cognitions and behaviors.

In their therapeutic approach, cognitive therapists collaborate with their clients to assess and change behaviors. Often in the therapeutic process, the therapist may take an instructional role, using techniques such as guided discovery and Socratic dialogue to identify maladaptive beliefs and help clients develop insights into their beliefs. Within the session, therapists often go over homework, examine current beliefs, and develop alternatives. As well as using behavioral and affective approaches, cognitive therapists make use of techniques such as decatastrophizing, labeling distortions, and cognitive rehearsal.

More than other theories, cognitive therapy has identified particular distorted beliefs that are typical of each of several psychological disorders. Of all the disorders, depression has received the most attention, as it was the focus of Beck's early therapy and research. Just as there has been much emphasis on specific approaches to each psychological disorder, researchers have studied the effectiveness of a variety of cognitive approaches to many common psychological disorders, often comparing cognitive treatments to behavioral and pharmacological approaches.

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### Suggested Readings

- BECK, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford. • Written by Aaron Beck's daughter, Judith, this is an excellent overview of cognitive therapy. Diagrams and case examples add to the clarity of this book.
- CLARK, D. A., BECK, A. T., & ALFORD, B. A. (1999). *Scientific foundations of cognitive therapy and theory of depression*. New York: Wiley. • The rationale for the treatment of cognitive therapy of depression is presented in thorough detail. This complex and comprehensive book describes many aspects of the cause of depression from a cognitive point of view.
- FREEMAN, A., & DATTILIO, F. M. (1992). *Comprehensive casebook of cognitive therapy*. New York: Plenum. • A brief explanation of treatment strategy along with a case history are given for about 30 different psychological disorders and/or patient populations. The case examples are particularly helpful in understanding a cognitive therapy conceptualization of psychological dysfunction.
- PERSONS, J. B., DAVIDSON, J., & TOMPKINS, M. A. (2000). *Essential components of cognitive-behavior therapy for depression*. Washington, DC: American Psychological Association. • This clearly written treatment manual follows a brief approach to the treatment of depression that relies heavily on Beck's treatment method.

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