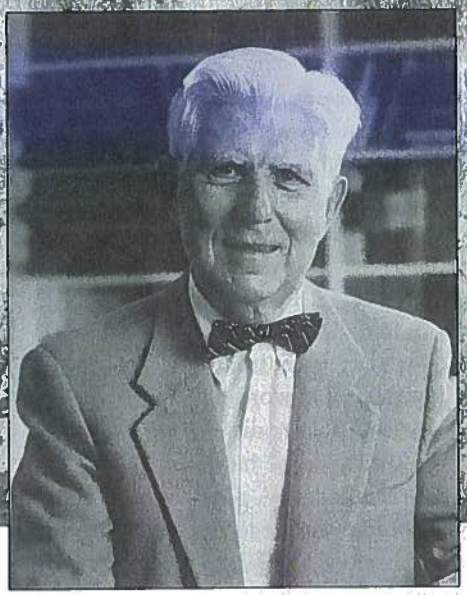

Aaron T. Beck

CHAPTER 10

Cognitive Therapy

Steve is a 38-year-old Caucasian male. He lives in a residential treatment facility for recovering substance abusers and participates in a work-therapy program sponsored by a local hospital.

Steve is the only child of an upper-middle-class family. He characterizes his family life as "swell," like "Beaver Cleaver." Steve reports that his father was a great provider but that their relationship was distant. His relationship with his mother was similar.

When he was in third grade, Steve was sent to a private military academy. In seventh grade, he switched to public school, but was subsequently expelled for "acting up" (he wore a bikini to school one day). After he was expelled, Steve reentered the military academy, from which he eventually graduated.

When Steve was 11, his parents separated, and then divorced. Steve lived with his mother, who remarried when he was 17. He remembers his mother as being very sad about the divorce, but that she "put up a strong front," assuring him that "things would be all right."

After graduating from the military academy, Steve entered the navy, where he served for 4 years. After his discharge, he was working in an auto body shop when he discovered blood in his urine. He reports that his father sent him to the Mayo Clinic, where he was found to have a lesion on his left renal tube. Steve reports that his first episode of depression occurred at this time and that his first episode of mania occurred shortly thereafter. After seeing a psychiatrist, he was diagnosed as bipolar and treated with lithium.

In 1990 Steve was engaged to be married. Around that time he was involved in an automobile accident that resulted in the death of the driver of the other vehicle involved. Steve reports that he does not remember the accident because he was intoxicated (alcohol) but that the police determined that the accident was the other driver's fault. Nonetheless, he was charged with manslaughter, placed on probation, and ordered to pay $10,000 in

restitution. During this period, Steve's father was supportive, but his grandparents told him that his mother had announced to friends and family that she had "disowned" Steve.

After these events, Steve's fiancée presented him with the ultimatum that if he drank alcohol again she would leave him. He reports that he stopped drinking easily. A year later, Steve's fiancée left him, and he resumed drinking. About 4 months later, Steve admitted himself voluntarily to the local Veteran's Administration Alcohol and Drug Abuse Treatment Unit. Steve has subsequently relapsed and returned to treatment twice. He is currently medicated with antabuse and lithium.

Steve is in counseling as part of his participation in the work-therapy program. He says that he is too immature and that he sacrifices self- and others' respect when he "acts out." Steve reports that he basically accepts himself as he is, but that sometimes he imagines his parents' point of view—their son is an "alcoholic and a manic-depressive" and this frightens and saddens him. He sometimes gets depressed about his situation. Steve tells his counselor that he wants to get back on his feet, get a good job, and become self-supporting.

BACKGROUND

The proper title Cognitive Therapy (CT) is typically reserved for the theoretical structure developed by Aaron T. Beck, beginning in the late 1960s. The development of this theory can roughly be divided into two phases: the period of schematic processing (pre-1990) and a newer variant of the theory that was proposed beginning in the mid-1990s (what I call the "modal" perspective; Beck, 1996, 1999; Clark & Beck, 1999). I will review both variants of the theory because the older theory has received significant research support and attention in clinical circles. Although the newer theory is an extension of the earlier version, it has received far less critical and empirical attention.

Before I proceed to further background, it is worth noting that in practice, the distinctions between Behavior Therapy (Chapter 8), Rational Emotive Behavior Therapy (Chapter 9), and Cognitive Therapy (Chapter 10) can get really blurry, at least if you are someone other than Judith or Tim Beck (see next paragraph). In fact, the term Cognitive Therapy is often used as a general label for a number of systems that emphasize the role of cognition in dysfunction and intervention. These approaches are also generally known as *Cognitive-Behavior Therapy*, and include Rational Emotive Behavior Therapy, problem solving, self-instructional training, and coping skills approaches (Arnkoff & Glass, 1995). In the real world, many therapists use a combination of techniques from all three approaches. However, if you follow the writings of the Becks, you will see that there is a very clear pure version of CT; you can watch Dr. Jennifer D. Lundgren do classic Cognitive Therapy with Helen on the *Theories in Action* DVD.

Aaron Temkin Beck was the son of Russian immigrants. According to Weishaar (1993), Lizzie Temkin, his mother, wanted to be a physician, but this was unheard of in the early 1900s. Lizzie married Harry Beck, a commercial printer with socialist leanings, and Aaron Beck was the youngest of their five children (born in 1921). The family was Jewish and very devoted to their religion.

Two of Beck's siblings died as children, leading to significant depression in his mother that abated only with Aaron's birth. As a result, Beck was overprotected by his mother (Weishaar, 1993). Beck almost died during his seventh year from sepsis that resulted from an infected broken bone. According to Weishaar (1993), this prolonged illness, hospitalization, and

surgery resulted in Beck developing anxieties and phobias. He also had difficulties because of missed school and was held back a year in the first grade. He thought he was dumb and that others thought so, too. These beliefs challenged Aaron to work hard, and he became an excellent student, graduating first in his high school class. During this period he acquired his nickname, Tim (for Temkin, his middle name), which is used by his close friends and wife (Weishaar, 1993).

Beck put himself through college at Brown, delivering papers and working as a door-to-door salesperson (Weishaar, 1993). He majored in English and political science, and a consult with a career counselor suggested that he should be a YMCA counselor! Warned about quota systems enforced against Jews, Beck still applied to medical school at Yale and received his MD in 1946. According to Weishaar, Beck admitted that his anxiety was one reason why he chose medical school—he wanted to defeat his blood-injury phobia. He acknowledged other fears as well, such as of abandonment, public speaking, and heights (Weishaar, 1993, p. 13).

After flirting with a career in neurology, he turned his attention to psychiatry and was classically trained as a psychoanalyst. Early in his career Beck was engaged in the science of psychotherapy, attempting to test Freud's hypothesis that depression was anger turned inward. Instead he found that depressed individuals sought the approval of others (Arnkoff & Glass, 1995). A subsequent series of studies investigating the construct of masochism in depression more clearly revealed that a distinguishing characteristic of depression seemed to be pessimism and negativity rather than masochism (Clark & Beck, 1999). At about the same time, Beck's clinical work was informing his theoretical development. He began to notice that his clients had thoughts during free association that they did not report (Beck, 1997a). Most of these thoughts had to do with the analytic relationship (worries about what the therapist thought of the client, for example), and they were closely associated with the client's current emotional state. Beck turned his attention to these thoughts (later labeled automatic thoughts) along with what he called the internal communication system, and Cognitive Therapy was launched (Beck, 1997b).

Beck acknowledges the contributions of other psychologists to his system, but maintains that he learned very little from existing theories of psychotherapy. Among the influences Beck recognizes are the philosopher Kant, and cognitive theorists Magna Arnold, George Kelley, and Albert Bandura. He characterized Albert Ellis as a pioneer whose ideas provided support for his (Beck's) break from traditional psychoanalytic ideas (Beck, 1991). Beck even uses the famous Epictetus quote usually associated with Ellis's REBT in his well-known 1976 book, *Cognitive Therapy and the Emotional Disorders* ("Men are not moved by things but the views which they take of them" Epictetus, cited in Beck, 1976, p. 47).

Beck is a prolific writer and researcher, having published hundreds of journal articles and many books. Both the medical and psychological communities have recognized his work. In 1989 Beck was awarded the American Psychological Association's Distinguished Scientific Award for the Applications of Psychology. He has also received the Association for the Advancement of Behavior Therapy Lifetime Achievement Award (1998) and the American Psychological Society James McKeen Cattell Fellow Award in Applied Psychology (1993). Beck is currently Professor Emeritus of Psychiatry at the School of Medicine at the University of Pennsylvania.

Beck founded the Beck Institute for Cognitive Therapy and Research in 1994. You can view its website at www.beckinstitute.org. Other websites of interest include the International

Association for Cognitive Psychotherapy at http://www.cognitivetherapyassociation.org, which publishes the *Journal of Cognitive Therapy: An International Quarterly.*

Beck's daughter, Judith, is a psychologist and cognitive therapist.[1] She is currently director of the Beck Institute. Judith's books *Cognitive Therapy: Basics and Beyond* (1995) and *Cognitive Therapy for Challenging Problems* (2005) present structured, easy-to-follow guidelines for the conduct of CT. If you want to try the CT approach to that diet you've been putting off, you could acquire Judith Beck's 2007 book, *The Beck Diet Solution.* Read a selection from *Basics and Beyond* in Box 10.1.

Box 10.1

Judith Beck on Automatic Thoughts

Automatic thoughts are a stream of thinking that coexists with a more manifest stream of thought (Beck, 1964). These thoughts are not peculiar to people with psychological distress; they are an experience common to us all. *Most of the time we are barely aware of these thoughts, though with just a little training we can easily bring these thoughts into consciousness.* When we become aware of our thoughts, we may automatically do a reality check if we are not suffering from psychological dysfunction.

A reader of this text, for example, while focusing on the content of this chapter, may have the automatic thought, "I don't understand this," and feel slightly anxious. He may, however, spontaneously (i.e., without conscious awareness) respond to the thought in a productive way: "I *do* understand *some* of it; let me just reread this section again."

This kind of automatic reality testing and responding to negative thoughts is a common experience. People who are in distress, however, may not engage in this kind of critical examination. Cognitive therapy teaches them tools to evaluate their thoughts in a conscious, structured way, especially when they are upset.

Sally, for example, when she is reading an economics chapter, has the same thought as the reader above. "I don't understand this." Her thinking becomes even more extreme, however: "And I'll *never* understand it." She accepts these thoughts as correct and feels quite sad. After learning tools of cognitive therapy, however, she is able to use her negative emotion as a cue to look for, identify, and evaluate her thoughts and thereby develop a more adaptive response: "Wait a minute, it's not necessarily true that I'll never understand this. I am having some trouble now. But if I reread it or come back to it when I'm fresher, I may understand it more. Anyway, understanding it isn't crucial to my survival, and I can ask someone else to explain it to me if need be."

Although automatic thoughts seem to pop up spontaneously, they become fairly predictable once the patient's underlying beliefs are identified. The cognitive therapist is concerned with identifying those thoughts that are dysfunctional, that is, those that distort reality, that are emotionally distressing and/or interfere with the patient's ability to reach her goals. Dysfunctional automatic thoughts are almost always negative unless the patient is manic or hypomanic, has a narcissistic personality disorder, or is a substance abuser.

[1]To minimize confusion, where I reference Aaron T. Beck's work, no initials are used.

Automatic thoughts are usually *quite brief*, and the patient is often more aware of the *emotion* she feels as a result of the thought than of the thought itself. Sitting in session, for example, a patient may be somewhat aware of feeling anxious, sad, irritated, or embarrassed but unaware of her automatic thoughts until her therapist questions her.

The emotion the patient feels is logically connected to the content of the automatic thought. For example, Sally thinks, "I'm such a dope. I don't really understand what [my therapist] is saying," and feels sad. Another time she thinks, "He's watching the clock. I'm just another case to him," and feels slightly angry. When she has the thoughts, "What if this therapy doesn't work? What will I do next?" Sally feels anxious.

Automatic thoughts are often in "shorthand" form but can be easily spelled out when the therapist asks for the *meaning* of the thought. For example, "Oh, no!" may be translated as "[My therapist] is going to give me too much homework." "Damn!" may be the expression of an idea such as "I left my appointment book at home and I can't schedule another appointment with my therapist today; I'm so stupid."

Automatic thoughts may be in *verbal form, visual form* (images), or both. In addition to her verbal automatic thought ("Oh, no!") Sally had an image of herself, alone at her desk late at night, toiling over her therapy homework (see Chapter 13 for a description of automatic thoughts in image form).

Automatic thoughts can be evaluated according to their *validity* and their *utility*. *The most common type of automatic thought is distorted in some way and occurs despite objective evidence to the contrary. A second type of automatic thought is accurate, but the conclusion the patient draws may be distorted.* For example, "I didn't do what I promised [my roommate]" is a valid thought, but the conclusion "Therefore, I'm a bad person," is not.

A third type of automatic thought is also accurate but decidedly dysfunctional. For example, Sally was studying for an exam and thought, "It's going to take me hours to finish this. I'll be up until 3:00 a.m." This thought was undoubtedly accurate, but it increased her anxiety and decreased her concentration and motivation. A reasonable response to this thought would address its *utility*. "It's true it will take a long time to finish this, but I can do it; I've done it before. Dwelling on how long it will take makes me feel miserable, and I won't concentrate as well. It'll probably take even longer to finish. It would be better to concentrate on finishing one part at a time and giving myself credit for having finished it." Evaluating the validity and/or utility of automatic thoughts and adaptively responding to them generally produces a positive shift in affect.

To summarize, automatic thoughts coexist with a more manifest stream of thoughts, arise spontaneously, and are not based on reflection or deliberation. People are usually more aware of the associated emotion but, with a little training, they can become aware of their thinking. The thoughts relevant to personal problems are associated with *specific* emotions, depending on their content and meaning. They are often brief and fleeting, in shorthand form, and may occur in verbal and/or imaginal form. People usually accept their automatic thoughts as true, without reflection or evaluation. Identifying, evaluating, and responding to automatic thoughts (in a more adaptive way) usually produces a positive shift in affect.

Excerpted from *Cognitive Therapy: Basics and Beyond* by J. S. Beck, 1995. New York: Guilford.

BASIC PHILOSOPHY

CT theory generally takes a neutral position on the properties of human nature. When the overall qualities of human existence are discussed at all, it is from an evolutionary perspective, which portrays humans simply as organisms adapting to the environment.

Alford and Beck (1997a) characterize CT theory as constructivist because it recognizes that a critical aspect of human existence is the creation of meaning from experiences. Unlike radical constructivist approaches (those that recognize no single objective reality), however, CT assumes both an external, objective reality and a personal, subjective, phenomenological one (Clark & Beck, 1999).

Beck would like to see his theory as the great integrator—that is, the "one" psychological theory that can explain all others (Alford & Beck, 1997a). One point in his favor is that the roots of the theory lie in both behavioral and psychoanalytic approaches. The behavioral roots of CT theory are evident in the techniques used in intervention, and in earlier versions of the theory that placed little emphasis on processes out of awareness. Beck wrote:

> The cognitive model was in part derivative from and in part a reaction against classical psychoanalysis. The derivative components consisted of the emphasis on meanings, the role of symbols and the generalization of reaction patterns across diverse situations . . . The "reaction against" consisted of eschewing the predominately motivational model, the notion of an unconscious cauldron of taboo drives defended against by repression and other mechanisms of defense, and the critical importance attached to the psychosexual stages of development. (Beck, 1991, p. 192)

Recently, CT theorists have begun to discuss the childhood origins of core beliefs, seeming to parallel psychoanalytic notions of the origins of dysfunction (Padesky, 2004). Also, current versions of CT theory pay much attention to cognitive processes that are not fully in awareness (e.g., automatic thoughts, cognitive schemas; these are discussed later) and are in this way reminiscent of Freud's ideas about the unconscious determinants of behavior.

A final point to note about CT theory is that it is mostly a theory of psychological dysfunction. Because it originated as a theory of depression (Beck, Rush, Shaw, & Emery, 1979) and also because it has been intimately tied to therapeutic practice, this theory tends to focus on the dynamics of psychological maladjustment rather than on healthy functioning.

Mia is Steve's counselor, and she follows a Cognitive Therapy approach. Assuming that Steve is a human like any other, she begins her work with him without any preconceived notions about his goodness or badness; he is simply a person striving to make sense of his environment. His behavior, in Mia's view, is in response to his current perceptions of his environment, which are tied to his early learning. She seeks to understand the way he thinks about things and how his cognitive process is related to his current situation.

HUMAN MOTIVATION

CT theory is probably best characterized as an adaptive theory. Beck draws on evolutionary theory to locate the motivation for human behavior in two major evolutionary goals: survival and reproduction (Beck, Freeman, Davis, and Associates, 2004). Cognitive processes evolved to enhance adaptation to the environment, and hence, survival (Clark & Beck,

1999). Humans struggle to comprehend the world and assign meaning to life events so that they can develop effective adaptive strategies (Alford & Beck, 1997a). "Cognition is implicated in controlling or directing behavior so as to maximize positive consequences (both short-term and long-term)" (Alford & Beck, 1997a, p. 64). The basic needs of humans are thought to be preservation, reproduction, dominance, and sociability (Clark & Beck, 1999, p. 67).

Mia assumes that Steve's situation is a result of many influences, but at the most basic level, he is struggling to adapt to his environment. He seeks positive consequences (survival, social contact, dominance or control of his situation, and intimate relationships). Mia looks at Steve's ways of construing the world in order to understand how his meanings relate to his behavior and feelings.

CENTRAL CONSTRUCTS

THE COGNITIVE MODEL

Simply put, the cognitive model, which is the foundation of CT, proposes that our emotions and behavior are the product of our *perceptions* of situations (J. S. Beck, 1995). "The cognitive view of behavior assigns primary importance to the self-evident fact that people *think*" (Kovacs & Beck, 1978, p. 525; italics in original). Cognition, in this model, means both the process and content of thinking, or how you think and what you think (Kovacs & Beck, 1978). Three levels of cognitive processing are seen in humans: the automatic or preconscious, the conscious, and the metacognitive (Alford & Beck, 1997a). The automatic level consists of thoughts and other cognitive organizations that are based in survival processes (see the later discussion of modes) that are largely out of awareness. The conscious level is what we normally think of as thinking, and the metacognitive level refers to our ability to think about our thought processes.

Of primary importance to Mia is how Steve thinks about things. She is also interested in the content of his thinking, and is aware that some of his thoughts might not be very accessible to him at present. Steve's emotions and behaviors are clues to his thought processes.

SCHEMAS

Schemas (sometimes also called schemata) are cognitive structures that organize the barrage of information with which we are constantly confronted (Beck & Emery, 2005). They help us create meaning out of what otherwise would be a bewildering array of stimuli, both internal and external. Schemas are the most basic unit of psychological function. Beck compares them to electrons in that they are theoretically critical elements that can only be indirectly observed (Alford & Beck, 1997b, p. 282). A formal definition of schemas is provided by Clark and Beck (1999): "Schemas are relatively enduring internal structures of stored generic or prototypical features of stimuli, ideas, or experience that are used to organize new information in a meaningful way thereby determining how phenomena are perceived and conceptualized" (p. 79).

Schemas can be dormant or active. To intuitively understand schematic processing, simply think of the word *librarian*. I am certain that you almost instantly came up with a set of images or words associated with the term. Further, if I told you someone was a

TABLE 10.1
EXAMPLES OF ADAPTIVE AND MALADAPTIVE SCHEMAS

Adaptive	*Maladaptive*
No matter what happens, I can manage somehow.	I must be perfect to be accepted.
If I work at something, I can master it.	If I choose to do something, I must succeed.
I'm a survivor.	I'm a fake.
Others can trust me.	Without a woman, I'm nothing.
I'm lovable.	I'm stupid.
People respect me.	People can't be trusted.
I like challenge.	The world is frightening.

Adapted from "Cognitive Therapy" by J. H. Wright and A. T. Beck, 1996, in R. E. Hales & S. C. Yudofsky (Eds.), *The American Psychiatric Press Synopsis of Psychiatry* (p. 1015). © 1996 American Psychiatric Press. www.appi.org. Reprinted with permission.

librarian, you'd be expecting the person to display those qualities. Your "librarian" schema is activated and is influencing how you respond to information.

Schemas influence the selection, encoding, and retrieval of information in the cognitive system. They contain general knowledge, core beliefs, and emotional elements relevant to a particular domain of experience (Reinecke & Freeman, 2003). If your librarian schema is activated, you are likely to observe features of someone that are consistent with your librarian schema, and you may have great difficulty recalling features that are inconsistent with the schema. You might also feel some emotion stemming from your past experience with librarians (did you get yelled at for talking in the library when you were a kid?). Some schemas are more easily activated than are others because they are broader, have more elements, and apply to more situations (i.e., are more complex; Clark & Beck, 1999). Adaptive and maladaptive schemas can be distinguished, as shown in Table 10.1. Box 10.2 illustrates an important schema dynamic, stereotype threat.

Box 10.2

The Power of Schemas

As you have read, schemas are the most basic unit of thinking and are developed either through personal experience with the world or through vicarious learning (watching what others do). Schemas are formed very early in life, even as early as infancy. When we experience new events, we store away information about those events for future use. For example, when Alexandra pets the family cat she discovers that the cat is soft, warm, and purrs. The next time Alexandra encounters a cat out in the environment, her "cat schema," which contains information about cats being soft, warm, and purring will

automatically be activated. Although schemas are the basic unit of thinking they can be quite complex. Each schema that we hold is based on one or more core beliefs about the world. So as you can imagine, if we hold faulty core beliefs about something, we are also going to activate faulty schemas that effect behavior. If Alexandra had been scratched by her family cat, she might then hold a core belief that all cats want to hurt her, which then would activate a negative cat schema that includes scratching and danger each time she sees a cat. As you can see, schemas can be very powerful and can be accurate or inaccurate based on the experience the individual has in the world.

Another example of the power of schemas is a dynamic called stereotype threat. Stereotype threat can be defined as anxiety aroused by the prospective risk of believing and confirming a negative stereotype about yourself because you belong to a group that has been negatively stereotyped. The threat then interferes with performance on tasks relevant to the stereotypic behavior. Although there are many examples of stereotypes that society has come to accept and advocate a troubling one in particular is that females (innately) have poorer math skills than males. A study done by Keller (2002) showed that when males and females were given a math test, they performed relatively equally. However, when students were informed before the test of the stereotype that males typically scored higher than females, the females performed more poorly than males.

Similar results were found when Steele and Aronson (1995) examined racial stereotypes with White and African American students on intelligence tests. In this study it was found that if African American students were primed with a racial stereotype about test performance before taking the test, they did more poorly than White students on the test. However, if the African American students were not reminded of the racial stereotype before taking the test, no differences in performance were observed.

Another example of stereotype threat that has been documented in the literature by Koenig and Eagly (2005) addresses the common stereotype that women are more socially sensitive than men. In this experiment, men who were warned that the test they were taking tapped this social skill and that women were generally superior in this domain, scored lower compared to men who were told that the test measured information processing.

In light of this information, what schemas do you have, and how might then affect you?

Contributed by April L. Connery.

Mia's CT perspective tells her that Steve is surely harboring some maladaptive schemas. These schemas are influencing how he sees the world, including what he pays attention to and how he behaves and feels. Mia thinks that Steve probably operates, at times, from schemas such as, "I'm a fake and a failure" but also from some manic schemas that are grandiose ("I am strong and powerful and can get away with a lot. I should take advantage of this. I can drink and act up and why not?").

Beliefs

As just noted, beliefs are important components of schema, and as critical targets of Cognitive Therapy, are discussed extensively. Judith Beck (2005) distinguished between

two kinds of cognitions that are important in CT: core beliefs, and assumptions, roles and attitudes. Our schemas contain our **core beliefs**, which are the most basic beliefs we hold, and are thought to be the hardest to modify. They tend to be overgeneralized and absolute, and are usually self-referent (Clark & Beck, 1999). Assumptions, rules and attitudes, also known as **intermediate beliefs**, are situated between core beliefs and automatic thoughts (J. S. Beck, 2005; Clark & Beck, 1999). These beliefs include "should" and "must" beliefs as well as conditional beliefs that are influential in creating meaning from experience. An example of an assumption might be, "If I don't get an A in my Theories of Counseling course, then I am dumb." The intermediate beliefs also include rules or coping strategies used by individuals in reaction to other beliefs (J. S. Beck, 2005). These coping strategies are largely automatic and can be clearly distinguished from other forms of problem solving or coping responses. For example, an individual could hold the core belief "I am a failure" which is connected to the rule "I must get all As." A coping strategy would be, "I will achieve perfection in all of my coursework so that I get As." Clark and Beck (1999) added the most specific form of schema, the **simple schema**. Simple schemas deal with physical objects or very distinct, simple ideas, such as dogs, books, computers, and so forth.

As she begins her work with Steve, Mia looks carefully for evidence of his core beliefs and associated attitudes, rules, and assumptions. Because he does not appear to be psychotic, his simple schemas are intact. She thinks that some core beliefs may be, "I'm a goof-off and therefore nobody loves me" and paradoxically, "I am cool and can do what I want." Steve may bounce back and forth between these beliefs and associated schematic processing.

Steve's intermediate beliefs are linked to his core beliefs and schemas. Mia discovers that Steve thinks that he should please people so that they will love him and that that will make him worthwhile. When his manic schemas are activated, he probably thinks that the world must be good to him and allow him anything he wants. If it doesn't, he gets angry.

Automatic Thoughts

Automatic thoughts (ATs) are a normal feature of our cognitive process (J. S. Beck, 1995). They are swift, evaluative statements or images that exist alongside our more conscious thoughts. ATs tend to occur in shorthand rather than in full sentence form and often seem to just pop up out of nowhere (hence their name). Depending on their content, these thoughts can be functional or distressing, but in either case, they tend to be reasonable to the thinker (Beck, 1976). Usually, we are not particularly aware of our ATs we are more likely to be aware of the emotion associated with them. In reality, ATs are the result of our core and intermediate beliefs. They are thought to be easier to change than intermediate or core beliefs (J. S. Beck, 1995).

Judith Beck (1995) identified three general types of automatic thought. First are the distorted thoughts that are contrary to available objective evidence ("I never do *anything* right!"). Most ATs are of this type. A second type of ATs can be accurate, but the conclusion drawn is distorted ("I upset my boyfriend. Now he'll never love me again!"). A third type of ATs is accurate but dysfunctional (p. 77). This kind of thought either contributes

to a reluctance to approach a task or increases anxiety so that focus and concentration are disrupted. For example, I could have the automatic thought, "It's going to take a *long time* to finish this book!" This thought is true, but it may decrease my motivation to write, or it may distract me from my current writing activity because it definitely increases my anxiety.

Mia is interested in the automatic thoughts that might influence Steve's behavior. Probably he has some negative ATs, such as "I'm worthless," "Life is too hard," "I must not disappoint others," "I am not loved," and so forth. His drinking behavior is probably accompanied by thoughts such as, "What the hell," "I can handle it," "No use in trying to quit," and "I can't stand it without a drink." If he is in a manic swing, his ATs are things like, "I am great," "Others can't touch me," and "People had better be nice to me."

Modes

To more fully capture the complexity of human behavior, Beck proposed the concept of the mode, which is defined as "networks of cognitive, affective, motivational, and behavioral schemas that compose personality and interpret ongoing situations" (Beck & Weishaar, 2005, p. 239). Modal information processing is largely automatic and global, that is, schema-driven, particularly in the primal modes described later. Like schemas, modes are either active or dormant; when activated, modes tend to dominate behavior in a rather automatic way.

The **conscious control system** can override modal processing (Beck, 1996). This system is responsible for metacognition and intentional behavior, such as that based on personal goals and values. Logical reasoning and long-term planning are also products of the conscious control system.

CT proposes three major mode categories: primal, constructive, and minor. **Primal** modes are the most basic kinds of operation and function to meet the evolutionary goals of survival, procreation, and sociability (Beck & Clark, 1997). Because they are so basic to survival, they operate rapidly and automatically. Thinking in the primal modes is distorted and rigid (Beck & Weishaar, 2005). Clark and Beck (1999) identified four primal modes, although other sources seem to suggest others. For example, in their revised treatise on anxiety disorder, Beck and Emery (2004) stated that modes are "designed to consummate certain adaptational principles relevant to survival, maintenance, breeding, self-enhancement, and so on. Thus, we have a depressive mode, a narcissistic mode, a hostility mode, a fear (or danger) mode, an erotic mode, and so on" (p. 59). According to what I identify as one of the earliest formulations of modal theory (Clark & Beck, 1999), the four primal modes are threat, loss or deprivation, victim, and self-enhancement. Each mode contains a cluster of schemas: cognitive–conceptual, affective, physiological, motivational, and behavioral. A description of these modes is shown in Table 10.2. The first three modes (threat, loss, and victim) evolved to protect the organism against threats to survival. The self-enhancement mode works in the opposite manner to the first three modes to enhance the survival and adaptation of the person.

Beck (1996) argued that primary modes are not inherently dysfunctional because they serve to enhance human survival. For example, it is very adaptive to mobilize the organism to fight or flee in the face of threat. Unfortunately for us, our environment has

TABLE 10.2
THE FOUR PRIMAL MODES

Mode	Characteristics
Threat	Perception of threat
	Feelings of anxiety or anger
	Physiological arousal
Loss	Perception of possible or actual loss of vital resources
	Feelings of dysphoria (depression) or sadness
	Fatigue or physiological deactivation
Victim	Perception of injustice or offense against the self and self-interests
	Feelings of anger
	Physiological activation
Self-enhancement	Perception of achieved or anticipated personal gain
	Feelings of happiness
	Physiological activation

Adapted from D. A. Clark & A. T. Beck (1999), *Scientific Foundations of Cognitive Theory and Therapy of Depression* (pp. 89–91). Copyright © 1999 by John Wiley & Sons, Inc. This material is used by permission of John Wiley & Sons, Inc.

changed a bit from that in which the primary modes evolved, causing a "mismatch" at times in which modal behavior is not necessarily the best strategy to deal with the complex situations we encounter (Beck, 1996). Even what we think of as positive modes (self-enhancement) can become exaggerated, as in mania (or bipolar disorder), and are therefore dysfunctional.

The second class of modes is termed the **constructive** modes (Clark & Beck, 1999). These modes are developed primarily through life experience and serve to increase the life resources available to the individual. They are associated with positive emotions and adaptive characteristics and include (a) the capacity for intimacy, (b) personal mastery, (c) creativity, and (d) independence. As you can observe from Table 10.2, one of the primal modes is constructive as well, the self-enhancement mode.

The **minor** modes are the third category of thinking and tend to be under more conscious control than the other modes. They tend to be narrowly focused on situations and include everyday activities such as reading, writing, social interaction, and athletic or recreational activities (Clark & Beck 1999).

Mia listens very carefully to Steve. She thinks that he operates out of several of the primal modes that periodically dominate his cognition and behavior. First, his feelings about his parents and perhaps some of his drinking behavior seem to flow from a loss mode because he sometimes drinks because he is depressed or upset. He is unhappy with his irresponsible behavior, indicating a poor self-concept associated with the loss mode, as well as weak constructive modes. At other times Steve shows overactivation of the self-enhancement mode in

his manic behavior. During these episodes he is likely to be hyperactive, show irrational positive emotion, and have an inflated view of himself and his capacities. Steve's drinking can also occur when he is functioning in a manic fashion, because the grandiose schemas associated with this mode include thoughts of invincibility. When he fails or the world does not treat him as he wishes, his victim mode is activated. At these times, he can become angry and aggressive.

It is evident to Mia that Steve is able to use his conscious control system sometimes to override his activated primal modes. The operation of this system is what gets him to treatment after he has relapsed into substance use. It is also what helps him evaluate his acting-out behavior and set goals for the future.

THEORY OF THE PERSON AND DEVELOPMENT OF THE INDIVIDUAL

In discussing human development, CT theorists conceptualize human functioning as the product of learning and genetics. Drawing on literature in developmental psychology, Beck and his associates start with the notion that certain personality tendencies can be genetic in origin, such as sensitivity to rejection by others or dependency (Beck et al., 2004).

As children, we strive to make sense of our environments (including our selves and others) and organize this information into schemata (J. S. Beck, 2005). The tendency to create meaning through the use of schemas is thought to be innate (Clark & Beck, 1999). Based on the amounts of positive and negative experiences we have, we develop corresponding views of ourselves and the world. A kid who gets a lot of glowing feedback will develop a positive set of schemata about himself and the world and will therefore be less likely to develop faulty cognitive processes. Modal theory (Beck, 1996) replaces the construct of schemas with that of **protoschemas**, which are innate patterns that interact with experience to develop the modes.

Previous versions of CT theory did not elaborate a theory of personality. More recently, two general dispositions have been identified, autonomy and sociotropy (Beck, 1997b; Beck and Weishaar, 2004). Individuals who are high in sociotrophy find their self-worth in relations with others. Autonomous individuals emphasize mastery and independence and build self-esteem through achievement and control (Clark & Beck, 1999). Different kinds of life experiences, then, will differentially affect individuals who are oriented toward one dimension or the other. For example, an interpersonal conflict would have much different ramifications for a sociotrophic than for an autonomous individual. Beck and his associates, however, acknowledge that pure types are relatively rare: most people display tendencies of both sociotrophy and autonomy (Beck & Weishaar, 2004).

Under normal circumstances, we tend to operate via simple schematic processing and with our conscious control system (Beck, 1996). We cruise along, using minor modes to attend to everyday activities. These schemas are activated and have some cognitive, affective (usually mild), and behavioral effects, but these effects dissipate quickly. Occasionally (or often, if you are dysfunctional), information is present that matches an **orienting schema** that is linked to a primal mode. When a match is made, the primal mode is activated; the cognitive, affective, behavioral, and physiological systems or schemas are energized; and primary modal processing is seen (Beck, 1996). The kinds of behavior, affect,

and cognition observed will depend on whether the primary mode activated is one of the constructive modes or one of the defensive or protective modes.

Steve appears to be more sociotrophic than autonomous in his orientation. Mia thinks that his early experiences in his family resulted in the formation of schemas emphasizing the value of the love of others. He likely grew up wanting close relationships with his parents, but never achieved these. He may also have experienced the loss of these relationships because of his parents' conditional acceptance of his behavior. Steve's cognition and behavior suggest that as he matured, the loss primal mode may have been very alive, and so even now, this mode and accompanying schemas are sensitive and easily activated. Also, it appears that early on, his self-enhancement primal mode was hyperactive, as evidenced by his acting-out behavior at school.

HEALTH AND DYSFUNCTION

"Contrary to common belief among clinicians, the cognitive approach to depression and psychopathology does *not* assume that a well-adjusted individual is one who thinks logically and solves problems rationally" (Kovacs & Beck, 1978, p. 528; italics in original). Presumably, people can function with illogical beliefs and irrational thoughts as long as they are not creating dysfunction. For example, one of my clients, Alex, believed that he was a flexible person. It was my observation that his cognitive and behavioral flexibility was limited. Alex had also received feedback from others to this effect. Fortunately, Alex did not see flexibility as crucial to his self-worth, so this inaccurate (i.e., not consensually validated) belief was not dysfunctional for him.

Although CT theorists don't spend a lot of time discussing healthy psychological functioning, it appears that the CT version of health would include information processing that allows the individual to meet his goals of survival, reproduction, and sociability. We can infer that healthy folks don't rely on a lot of primary mode processing and don't show a lot of distorted thinking. The constructive modes of processing are more in evidence, and the individual is able to use the conscious control system to moderate schematic processing. The healthy person probably has fairly good problem-solving skills, too.

In viewing dysfunction, Beck and his collaborators have emphasized an interactive view. For instance, Beck and Weishaar (2005) contend that "psychological distress is ultimately caused by many innate, biological, developmental and environmental factors interacting with one another, and so there is no single 'cause' of psychopathology" (p. 246). However, the focus in most of CT theory is, predictably, cognition. J. S. Beck (2004) writes "the cognitivist assumes that the individual's primary problem has to do with his construction of reality. The remedy lies in modifying the cognitive set. The psychological modification then produces biochemical changes that in turn can influence cognitions further" (p. 200). Despite this strong statement, Beck does allow that pharmacological interventions can cause cognitive-neurochemical change. Writing specifically about depression, Young, Beck, and Weinberger (1993) put it this way: "The pharmacotherapist intervenes at the biochemical level; the cognitive therapist intervenes at the cognitive, affective, and behavioral levels. Our experience suggests that when we change depressive cognitions, we simultaneously change the characteristic mood, behavior, and (we presume) biochemistry of depression. The exact mechanism of change, however, remains a target of considerable investigation and debate" (p. 241).

Very early in his theoretical journey, Beck (1976) identified a number of cognitive problems that are characteristic of depressed individuals (see Figure 10.1). These **cognitive distortions** remain important theoretical constructs in CT theory. Each of the problems outlined in Figure 10.1 is followed by an example of Steve's cognitive distortions. Because much of Beck's early thinking was oriented to depression, another useful concept is the **cognitive triad**, which refers to the depressive's negative views of the self, the world, and the future (Kovacs & Beck, 1978).

Distorted thinking results from faulty schemas and their associated core beliefs. Young and colleagues (1993) described the "deepest" type of schemas, the early maladaptive schemas (p. 242). These cognitive structures develop very early in life as a result of interactions with the surrounding environment, most notably those with significant others. After the schema is created, it can be activated by environmental or internal events, and information processing becomes selective—information that is consistent with the schema is admitted to awareness, whereas inconsistent information is distorted or rejected. In this way, the maladaptive schema is maintained.

These schemas are resistant to change, connected to significant emotional responses, and if examined by the client, perceived as absolute truths (Young et al., 1993). A client would simply say, "That's just the way I am!" An example of such a schema might be called the rotten person schema. This person would be totally convinced that he can't do anything right and that others hate him. J. S. Beck (2005) identifies three broad categories of negative core self-beliefs that would be seen in a rotten person schema: helplessness, unlovability, and worthlessness.

Beck and colleagues, over the years, have identified specific ways of thinking and perceiving that are characteristic of various psychological dysfunctions. Beck calls this idea the **cognitive specificity principle** (Beck, 2005). In anxiety disorders, for example, the individual is hypervigilant, focused on signs of danger or threat (Beck & Emery, 2005). Automatic thoughts of threat and harm come easily and often. Other examples of dysfunction-specific beliefs are seen in drug-abusing clients who harbor "need" beliefs such as, "I can't stand the boredom without my drug" (Beck, 1993). Individuals who display bipolar disorder are thought to have both depressive beliefs and beliefs such as, "I have exceptional powers and should use them" (Beck, 1993).

The idea of cognitive specificity allows the extension of CT theory to various kinds of psychological dysfunction. Much attention has been paid to anxiety disorders, including panic disorder (Beck & Emery, 2005). Other conceptualizations have focused on eating disorders (Edgette & Prout, 1989), substance abuse (Beck, Wright, Newman, & Liese, 1993), and even schizophrenia (Beck & Rector, 2000; 2005).

The revision of CT proposed by Beck (Beck, 1996; Clark & Beck, 1999) locates the source of psychological dysfunction in overactive primal modes (Beck, 1996). We are all born with the protoschemas for primal modes. Through experience, the primal modes are constructed and endowed with energy (or "charged"; Beck, 1996, p. 8). A series of experiences relevant to a specific mode will result in the mode being fully activated and operative. As Beck explains it, "A particular mode is generally silent or latent at first, but through successive relevant experiences can receive incremental charges until it reaches the threshold for full activation. In some psychopathological conditions—for example, recurrent depression—the mode is chronically but subliminally charged so that it can become fully activated after a comparatively minor stressful event (the kindling phenomenon)" (Beck, 1996, p. 8).

1. All or nothing thinking (black-and-white, polarized, or dichotomous thinking). Life is seen in rigid categories; no shades of gray are allowed. *Steve believes that he must be perfect in the eyes of important others to maintain self-respect.*
2. Catastrophizing (fortune telling). The future is viewed as a disaster; other kinds of outcomes are not considered as even remote possibilities. *Steve is sure that the future holds nothing but gloom; he will never get a job he likes nor regain his relationship with his mother.*
3. Disqualifying or discounting the positive. Good stuff just does not count! *Steve downplays his previous successes. He does not acknowledge that, despite his slips, he has been able to get himself to treatment and is currently doing well in the work-therapy program.*
4. Emotional reasoning. Because of the emotional investment in an idea, it is seen as true, regardless of discrepant information. *Steve is deeply hurt by his mother's disowning him and feels certain that she is right; he is worthless.*
5. Labeling. A global rating is made (of self or other). *Although Steve says he accepts himself, his reports that he worries about the opinion of his parents suggest that he may not be as self-accepting as he says he is. He may be rating himself negatively, which would be consistent with his early experience.*
6. Magnification/minimization. Negative information is highlighted; positive information is ignored or minimized. This kind of thinking is the opposite of wearing rose-colored glasses. *If Steve makes a mistake at work, he worries terribly that he'll be perceived as a bad worker and get fired. He does not attend to the things he does well at work.*
7. Mental filter (selective abstraction). One negative detail is attended to, resulting in a conclusion that does not consider other factors in a situation. *Steve's supervisor was curt with him, and Steve concludes that his supervisor is angry or unhappy with him. He does not consider that his supervisor has many other demands on her, and that she was brisk with other workers as well.*
8. Mind reading. Need this one be described? *Steve believes he knows exactly what his mother and father think of him.*
9. Overgeneralization. The conclusion (usually negative) becomes larger than is justified by an event. *Because Steve has not succeeded in staying "dry" previously, he concludes that he will never be able to achieve his goal of sobriety.*
10. Personalization. Another person's behavior is attributed to oneself without considering alternative explanations. *Steve's supervisor announces a new rule at work—anyone who gets angry must leave for one hour. Steve assumes that the rule was made in response to his outbursts and feels depressed.*
11. Should and must statements. Rigid rules for life, which, if not met, create a catastrophe. *Steve believes that he must be perfect so that others will love him. Others must not show disapproval of him.*
12. Tunnel vision. A narrow focus on the negatives. *Steve sees his life in terms of his immature behavior, substance abuse, and cycles of mania and depression. He fails to recognize his strength in getting help and trying to turn his life around. He also ignores his successes in his current working environment.*

FIGURE 10.1. Cognitive Distortions.
Adapted from *Cognitive Therapy: Basics and Beyond* (p. 119) by J. S. Beck, 1995, New York: The Guilford Press. Adapted with permission.

TABLE 10.3
MODES AND DIAGNOSTIC CATEGORIES: PRIMAL SYSTEMS

Disorder	*Cognitive Features*	*Affective Features*	*Behavioral Impulse*	*Physiological Activation*
Specific phobia	Specific danger	Anxiety	Escape or avoid	Autonomic nervous system
General fear	Generalized danger	Anxiety	Escape, avoid, inhibit	Autonomic nervous system
Hostility	Threatened, wronged	Anger	Punish	Autonomic nervous system
Depression	Loss	Sad	Regress	Parasympathetic activation

Adapted from "Beyond Belief: A Theory of Modes, Personality, and Psychopathology," in P. M. Salkovskis (Ed.), *Frontiers of Cognitive Therapy*, 1996, New York: The Guilford Press.

According to Beck, the various categories of psychological dysfunction (as classified in the *DSM*-IV, for example) can be understood in terms of the specific primal mode involved and the characteristic "goal" of the mode (1996, p. 8). For example, in depression, the loss threatens the organism's livelihood, and the behavioral inactivation so common to depression represents a means of preserving the organism. Further, depression is typically accompanied by a weak constructive mode, so the individual probably has poor self-concept and a decreased ability to think constructively (Beck, 1996). Table 10.3 shows Beck's (1996) conceptualization of the psychological disorders and associated modal functioning. Note that Beck includes hostility among these because he believes that it is needed to account for excessive violence and homicide.

Recently, CT theorists have become interested in the struggle to work with clients diagnosed as having personality disorders. Although she doesn't invoke modal theory, J. S. Beck (2005) notes that "cognitive therapists view the development of Axis II disorders as the result of an interaction between individuals' genetic predispositions toward certain personality traits and their early experiences. A histrionic patient, for example, may have been born with a flair for the dramatic" (p. 41).

Mia thinks that Steve's most active schema is the depressogenic schema. He shows the negative triad in his dim view of himself, his perception that others don't like or approve of him, and his perception that the world is difficult and the future is uncertain or negative. Mia guesses that although Steve's loss mode is somewhat active at present, it is not fully charged because he evidences mild to intermittent and moderate, rather than severe, depression. Because of Steve's apparent sociotropic orientation, Mia will be on the lookout for interpersonal situations that could set off more extreme modal processing.

Steve's loss primal mode was probably sensitized by his early experiences with his parents. They were distant in their interactions with him, and he interpreted the distance as rejection based on his inadequacy and bad behavior. The victim mode might be relevant to Steve's situation as well because he sometimes sees himself as the scapegoat of an unfair world (for instance, in the automobile accident). Steve may also have been born with genetic tendencies toward passive, depressive types of behavior.

When Steve's loss mode is activated, he withdraws and drinks to escape. He shows evidence of cognitive distortion in this situation ("it's no use; I can't do anything right; why bother to try to stop drinking when the world is so awful"), low motivation, and behavioral inactivation. If Steve's victim mode is also activated by his perception of some injustice, he may feel threatened and angry, too. At these times, he may seem energized by the anger.

Occasionally, Steve enters a manic phase that results from activation of the self-enhancement mode. At these times, he may drink because he believes himself invincible. He acts out because he has an exaggerated sense of his power. If his victim mode becomes activated at the same time, he may physically attack the person or entity perceived to be threatening him. When the manic mode is active, he probably has automatic thoughts such as, "what the hell," "one drink is fine," and "everyone loves me."

NATURE OF THERAPY

ASSESSMENT

Both formal and informal assessment is used in CT. Newman and Beck (1990) strongly encouraged a formal comprehensive diagnostic evaluation for three reasons: (a) to fully understand the psychological picture of the client, (b) to determine if any organic syndrome is involved, and (c) to assess the need for medication or hospitalization. Ultimately, the goal of the assessment is a structured cognitive case conceptualization (J. S. Beck, 1995, 2005; Persons & Tompkins, 1997). Often, a special session (i.e., intake) is used for assessment prior to the official start of counseling (J. S. Beck, 1995). The initial evaluation generally results in a formal *DSM*-IV diagnosis.

Formal assessment in CT often involves using standardized self-report inventories such as the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, & Erbaugh, 1961), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988), the Automatic Thought Questionnaire (ATQ; Hollon & Kendall, 1980), or the Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978), which measures schema-related core beliefs and assumptions. The latest of these tools seems to be the Beck Cognitive Insight Scale (Beck, Baruch, Balter, Steer, & Warman, 2004). Numerous other instruments have been constructed for cognitive assessment; an excellent review of these and their psychometric properties is presented by Blankstein and Segal (2001). These instruments are often used intermittently throughout counseling to assess progress (Persons & Tompkins, 1997).

CT counselors are most interested in assessing their clients' thoughts, and they do this continually throughout therapy. The simplest way to make this assessment is to simply ask the client, "what was going through your mind?" either in reference to a mood change in session, or in helping clients reconstruct situations outside of therapy. As I noted earlier, the Dysfunctional Attitude Scale or Automatic Thought Questionnaire can also be used for this purpose.

Cognitive assessment leads to a formal treatment plan. In the first session of CT, the client is asked to establish goals; the therapist helps the client to make these specific and concrete. The CT counselor then takes each problem or goal and analyzes it from a CT perspective (J. S. Beck, 1995; 2005). J. S. Beck's recent writings emphasize the creation of a formal cognitive conceptualization for each client, using a format she specifies in her recent book (2005).

Mia gives Steve the Beck Depression Inventory to assess his current level of dysphoria. She finds that he is moderately depressed. She also spends time in the first (and later sessions) helping Steve identify his cognitions, first his automatic thoughts, and later his core beliefs. She considers using the Dysfunctional Attitude Scale to assess his core beliefs and assumptions.

Overview of the Therapeutic Atmosphere

Advocates of CT agree that it is structured, active, collaborative, and psychoeducational (Reinecke & Freeman, 2003). Cognitive, behavioral, and imaginal techniques are used.

CT is characterized by a collaborative relationship between client and counselor (Beck & Emery, 2004). Cognitive therapists recognize the importance of the therapeutic relationship, sounding much like person-centered theorists in their emphasis on warmth, genuineness, trust, and respect (Newman & Beck, 1990). J. S. Beck (2005) and Beck and Emery (2005), however, note that the therapist must be alert to signs from the client that the nature of the relationship needs to be modified. For example, highly sociotropic clients might need more warmth from the therapist than would those lower on this dimension (Beck & Emery, 2005).

The CT relationship is seen as different from other counseling relationships because it emphasizes a scientific approach (Beck, 1997a); the relationship is said to be based on **collaborative empiricism** (Beck & Weishaar, 2005). Client and counselor are co-investigators in the scientific study of the client's difficulties (Reincke & Freeman, 2003). The client's schemas, beliefs, and automatic thoughts are treated as hypotheses to be tested by the two scientists (Young et al., 1993). Evidence is gathered and experiments are designed and conducted to test the hypotheses.

Alford and Beck (1997c) discussed the role of interpersonal support in CT. They maintained that the therapist must create "responsible dependency" in the client; the client is not to become passive in the relationship (p. 107). Support in CT means support of the efforts of the client to learn and implement the CT model in his life. The therapist makes genuine efforts to understand the client and accepts the client in the sense that all client cognitions, feelings, and behaviors are openly examined for their advantages and disadvantages (Alford & Beck, 1997c). However, the cognitive therapist does not accept certain client actions and goals when they are considered antisocial (e.g., illegal acts, abuse of others).

Beck (1976) calls CT a common-sense therapy that simply helps the client apply problem-solving techniques that he has used in the past to correct the current faulty thought processes. CT is typically a short-term intervention, ranging from 10 to 20 sessions (Wright & Beck, 1996). For more severe problems (e.g., personality disorders), CT can be longer, but it is still considered a comparatively brief approach to these dysfunctions. Booster sessions are often scheduled after formal termination to help prevent relapse (J. S. Beck, 1995).

Mia approaches Steve in a friendly, warm way. She is accepting of him and sometimes responds empathically to his description of his troubles, hopes, and dreams. Mia attempts to build a relationship based on the idea that she and Steve will look at how he views the world, testing out the conclusions he draws and determining their relationship to his feelings and behavior. Mia expects that if Steve becomes engaged in their scientific counseling project, he will be in therapy for about 6 months. However, the length of Steve's counseling will likely depend on what goals he sets.

Roles of Client and Counselor

In CT, the counselor is an expert who teaches the client about Cognitive Theory (Alford & Beck, 1997c). In this way, the relationship somewhat resembles that of doctor-patient. Judith Beck characterized the cognitive therapist as simultaneously caring, collaborative, and competent (1995, p. 304). The counselor typically is very active, particularly early in the therapy process (Wright & Beck, 1996). Cognitive therapists ask their clients a lot of questions and are very likely to assign tasks related to the clients' identified problems.

Initially, the client is a student who is expected to work hard to learn about CT. He is expected to devote energy to examining his thought process, and to complete homework assignments. At the same time, the client is a collaborator in the counseling process whose direct input is always solicited in setting session agendas and selecting homework assignments (Wright & Beck, 1996). As therapy progresses, the client is expected to take more and more responsibility for what happens in counseling sessions, developing CT explanations for his feelings and behaviors, setting the session agenda, and developing homework tasks. In essence, the client becomes an expert on how CT theory applies to him (Alford & Beck, 1997c).

Mia takes a straightforward, educative approach with Steve. She explains the cognitive model to him in the first session, attempting to get him to understand and accept the system and engage collaboratively with her in the process of CT. She gives Steve a pad of paper and a pen and encourages him to take notes about the model. Mia is very aware that it will be important to establish a good working relationship with Steve because he is a sociotropic type who is sensitive to the evaluations of others. She is supportive of his efforts to learn and apply the model.

If Steve responds well to Mia's invitation to participate, he will become a good student of CT. Steve will work in tandem with Mia to identify his cognitive processes and to understand how they relate to his feelings and behavior. He will follow Mia's instructions in his sessions and complete his homework assignments. The two will engage in collaborative empiricism, testing Steve's ideas in a CT model.

Goals

The goals of CT are to identify and change faulty information processing and to modify beliefs that support psychological dysfunction to ones that are more adaptive (Beck & Weishaar, 2005). Typically, a good deal of this work focuses on the client's automatic thoughts (J. S. Beck, 2005). Through addressing automatic thoughts, basic beliefs or schemas are sometimes accessed, but significant change in these deeper structures may require longer-term therapy than is typical in CT. A broader goal of CT is to teach clients problem-solving strategies that they can use across situations.

Altering faulty core beliefs and the associated schematic change, although difficult, should prevent relapses (Young et al., 1993). The idea is to get the individual to operate based on reflective, constructive processes through the use of the conscious control system, or metacognition, rather than primitive schemas (Beck & Clark, 1997). The dysfunctional modes need to be deactivated and the more adaptive modes need to be built (Beck & Weishaar, 2005). Modifying the content of the modes is yet another way to achieve more adaptive behavior, which is achieved through addressing core beliefs and schemas.

Steve is harboring some faulty beliefs that need to be modified. Mia helps him identify his automatic thoughts (ATs) first, and then replace them with more functional beliefs. For instance, the AT that "no one loves me" needs to be replaced with something less drastic.

Mia is sure that Steve's self-enhancement primal mode needs to be strengthened. This process will be tricky because Mia is aware that sometimes Steve's functioning based in this mode gets exaggerated (when he is manic). Steve will need to learn to use his conscious control system to discriminate between these two states. Mia decides that Steve needs to find ways to deactivate or de-energize his primal loss and victim modes and to use his conscious control system to interrupt this modal processing when it occurs. Mia targets Steve's problematic ATs and intermediate beliefs as a way to start this process. Later in therapy, he can begin to examine his core beliefs, schemas, and primal mode content and process.

PROCESS OF THERAPY

CT can be seen as moving through three general stages (Dobson & Shaw, 1988). In early sessions, behavioral activation is important. Once the client has some energy, the focus turns to specific automatic thoughts and their relationship to emotion and behavior. Finally (and some clients never get to this stage), the work turns to the more complex level of schematic processing.

In the first session of therapy, three goals are considered critical: establishing the working relationship, goal setting, and socializing the client (Newman & Beck, 1990). Young and colleagues (1993) added that rapport is enhanced and the client's suffering reduced if the therapist can create some quick symptom relief in the first meeting. Judith Beck agreed, writing that "one of the best ways to strengthen the therapeutic alliance is to help patients solve their problems and improve their mood" (2005, p. 67).

Socialization involves directly teaching the cognitive model. A second important part of the educative process is teaching the client about the structure of counseling sessions. Each CT session can be partitioned into seven segments (J. S. Beck, 1995): (a) brief update, (b) bridge from the previous session, (c) setting the agenda, (d) review of homework, (e) discussion of the issues, (f) devising new homework, and (g) summary and feedback (p. 25). Although most of these segments are easily understood given their labels, two deserve extra comment. In the "bridging" stage, the counselor checks to see if the client understood what happened in the previous session. The summary and feedback segment includes the therapist's summary of the session, but also the opportunity for the client to evaluate the session. According to Judith Beck, the CT counselor is likely to ask the client, "Is there anything I said today that bothered you? Anything you think I got wrong?" (1995, p. 58).

Guided discovery describes the process of CT (Beck & Weishaar, 2005). The therapist has an idea (based on her cognitive conceptualization) about where she wants the client to end up, and through her questioning helps the client to get there (Beck, 1997a). Persons and Tompkins (1997) put it another way: "The goal here is for the patient to discover the answers she needs, guided by the therapist" (p. 328). Along the way, the therapist checks with the client often to see if they are in agreement on the goals and activities of the counseling (Persons & Tompkins, 1997). In Judith Beck's (1995) model, the counselor asks for the client's feedback at the end of each therapy session.

As counseling progresses, the counselor takes less responsibility and the client more for what happens in sessions. The therapist begins to take on an advisory role as the client conducts therapy (Young et al., 1993). Ultimately, the aim of the cognitive therapist is to help the client become his own counselor (Newman & Beck, 1990). Clients are even encouraged to conduct their own "self-therapy" sessions, following proper CT structure, after therapy terminates (J. S. Beck, 1995).

Although CT therapists recognize the existence of transference, the goal in CT is to keep these reactions to a minimum through the use of collaborative empiricism (Wright & Beck, 1996). If client transference does appear, it is treated like any other hypothesis—client and therapist explore the cognitive process around it and the evidence that supports or refutes it.

Beck and his colleagues (Beck, Freeman, & Associates, 1990) discussed client resistance under the heading of problems in collaboration. They suggested many possible reasons for noncompliance. Among these are lack of collaborative skills on the part of the client or counselor, client factors (stress, beliefs about change), client and therapist dysfunctional beliefs match (e.g., the therapist and client both believe the situation to be hopeless), poor socialization of the client, mistiming of interventions, and unclear or unrealistic therapy goals. J. S. Beck (2005) emphasized that it is important for the therapist to be attuned to the client's reactions in therapy, and to correspondingly modify her style to match the proclivities of the client. For example, she maintains that many clients like counselor-self disclosure, but some may wonder "why is this therapist wasting my time telling me about his problems?"

In her book on *Challenging Problems* (2005), J. S. Beck discusses difficulties in the therapeutic alliance, recognizing that these can stem from therapist errors or when the client's beliefs affect the alliance. When the problem is found to be the client's belief system, the therapist needs to determine whether it is a specific belief about the therapist or one about people and the world in general. For example, the client might harbor the core belief of helplessness, feel vulnerable, and avoid bonding with the therapist, or be overly protective and defensive. The therapist can then intervene with standard CT techniques. Reinecke and Freeman (2003) note that "the cognitive construct of schema activation is similar to the psychodynamic construct of transference" (p. 241)—that is, there are times when the client behaves in ways similar to those he employs outside of therapy. If this happens, the CT therapist does not attempt to deepen and elaborate upon the transference, but instead tries to help the client to become more aware of these reactions and change them (Reinecke & Freeman, 2003).

J. S. Beck also discusses therapists' dysfunctional reactions to clients and identifies a number of ways in which these can be addressed, such as attending to the competence of the therapist, assessing one's expectations for clients (are they too high or low?) giving feedback and setting limits, and practicing good self-care. In extreme cases, the client may be referred to a different therapist (J. S. Beck, 2005).

Mia and Steve begin their work with Steve learning the relationships among thoughts, feelings, and behaviors (the cognitive model). Mia asks Steve what he wants to get out of counseling, and he replies that he wants to get his life together and get a good job. Mia explores what "getting his life together" means. Steve lists the following (a) staying abstinent, (b) acting in more mature ways, (c) being less depressed and lethargic (which is also connected with his drinking), (d) establishing a better relationship with his parents, (e) feeling better about himself (despite his initial presentation of self-acceptance), and (f) getting a job.

Mia struggles to get Steve to be specific about his difficulties. She asks him what "acting out" and "immature" behavior are. He gives several examples: He yells at coworkers when he is frustrated. He has walked off the job when unhappy with how things were going (for example, when his supervisor is dissatisfied with his performance). He pouts when he does not get his way in group discussions at the residence facility where he lives.

Although his current level of depression is not as severe as it has been in the past, Steve would like to work on ways to deal with possible intensifications of depression in the future. He and Mia decide that setting some goals about depression would be appropriate.

Mia and Steve establish the following treatment plan:

1. *Develop strategies to help Steve stay abstinent from drinking. Identify situations that trigger drinking (those that activate the loss mode, primarily). Evaluate dysfunctional beliefs and automatic thoughts associated with drinking.*
2. *Help Steve identify and evaluate beliefs and thoughts about himself and his relationships with others, including his parents. Work on ways to improve these relationships.*
3. *Problem-solve about "acting-out" behavior. Identify beliefs and automatic thoughts associated with situations in which he feels criticized (i.e., the victim mode is operative). Construct alternative strategies to use in these situations.*
4. *Examine Steve's depression. Identify and evaluate cognitive structure and processes that are active when he is depressed (the depressogenic schema and associated beliefs and automatic thoughts).*
5. *Develop job-search behaviors and implement them. Examine cognitions around these behaviors.*

Mia's cognitive case conceptualization is shown in Figure 10.2, which guides her work with Steve. She helps him with his struggles, asking questions that orient his explorations (guided discovery). Mia gently encourages Steve to take responsibility for choosing topics to put on the agenda, and to take the lead in applying the cognitive model. In each session, they follow the steps of the CT model: (a) Steve gives a brief update on his situation. (b) Mia and Steve relate the previous session to the present. (c) Mia and Steve set the agenda. (d) They review the homework. (e) They discuss the issues on the agenda. (f) They construct new homework. (g) Mia summarizes the session and asks for Steve's feedback—how he felt about the session. Both Steve and Mia offer input.

THERAPEUTIC TECHNIQUES

Beck advocates the flexible use of techniques; almost any ethical technique that attacks dysfunctional thought is appropriate if the counselor and client agree on its use (Newman & Beck, 1990). "Cognitive therapy is highly eclectic, but not theoretically 'neutral'" (Alford & Beck, 1997a, p. 90). Techniques are selected to serve the overall conceptualization developed via cognitive theory (Alford & Beck, 1997a).

> Techniques can be selected from other psychotherapeutic approaches, provided that the following criteria are met: (1) The methods are consistent with cognitive therapy principles and are logically related to the theory of therapeutic change; (2) the choice of techniques is based on a comprehensive case conceptualization that takes into account the patient's characteristics (introspective capacity, problem-solving abilities, etc.); (3) collaborative empiricism and guided discovery are employed; and (4) the standard interview structure is

Client: Steve **Counselor:** Mia **Date:** 6-12-06'

Presenting Problems	Alcohol use, immature behavior, acting out, sadness/depression, unsatisfactory relationships.
Relevant History	Difficulty in school ("acting up"), family turmoil (distant parents, parental divorce), diagnosis of bipolar disorder at age 25, serious automobile accident, alcohol problems resulting in multiple courses of inpatient treatment, breakup of significant relationship.
Modes, Core Beliefs, and Schemas	Loss, victim, overactive self-enhancement modes. Self-schema negative ("I am worthless"). Believes that the world is generally hostile and unforgiving ("Others won't treat me well anyway"). Values the approval of others but doubts that he will get it ("I must be loved. Others disapprove of me.").
Conditional Beliefs	"If I don't keep my parents happy, then I am worthless. If others don't treat me well, they are evil and the world is a rotten place. If I am not perfect at work, I am a failure."
Situational Factors	When others criticize, interactions with parents, perceived failure of any kind.
Automatic Thoughts and Beliefs	*Associated with loss mode:* "No one loves me; I'm a failure and worthless; I must be perfect; I must not get angry; it's no use; I can't do anything right." *Associated with victim mode:* "Others are mean to me; others won't give me a break." *Associated with self-enhancement mode:* "I'm invincible; others can go to hell."
Emotions	Sadness and depression, anger and irritation in work environment, exhilaration in manic phases.
Behaviors	When depressed, becomes lethargic and may drink. In victim mode, can behave angrily and disrespectfully to others. Social/assertiveness skills weak?
Integration/Cognitive Construction of Current Presentation	Bipolar tendencies may be partly biological in origin. They are associated with loss, victim, and self-enhancement modes. Negative self-schema is a function of sociotrophic tendencies combined with early family environment and relationship with parents. Primal modes were also shaped by these factors. Different modes, when activated, are associated with emotions, behaviors, and cognitions as indicated earlier. Alcohol use appears in either loss or self-enhancement modes.

FIGURE 10.2. CT Case Formulation for Steve.

followed, unless there are factors that argue strongly against the standard format. (Alford & Beck, 1997a p. 91)

Both cognitive and behavioral techniques are used in CT. A general term for anything that changes client cognitive structure is **cognitive restructuring**. Behavioral techniques are used in the interest of behavioral activation (i.e., to get a severely depressed client moving as in activity scheduling) or to teach new skills (such as assertion or problem-solving training). **Homework** is considered essential in CT, and many of the techniques described in this section can be transformed into homework assignments (Beck & Emery, 2005).

The majority of presentations of CT focus on modifying or eliminating schemas, core beliefs, and automatic thoughts (e.g., Leahy, J. S. Beck, & Beck, 2005; J. S. Beck, 1995; 2005). Beck and Weishaar (2005) identified 3 ways to deal with dysfunctional modes: "(1) deactivating them, (2) modifying their content and structure, and (3) constructing more adaptive modes to neutralize them" (p. 240). According to Beck (1996), corrective information from the counselor activates a "safety" mode that contains more functional beliefs (p. 16). Basic cognitive-behavioral interventions that emphasize mastery and pleasure build or strengthen adaptive modes (Beck, 1996). Other interventions are oriented toward deactivating the protective primal modes. Routes to modal change include changing the appraisal of the situation (e.g., from dangerous to benign), distraction, and reassurance from the counselor (i.e., corrective information leads to change in how the client interprets the situation). The most significant change in primal modes, however, is through changing the underlying beliefs in the mode, the rules the individual uses to interpret the world. This belief change results in activation of adaptive modes and deactivation of dysfunctional modes (Beck & Weishaar, 2005). For example, a client who initially interprets a rapid heartbeat as the sign of an impending heart attack changes two beliefs: (a) that rapid heartbeat always leads to heart attack and (b) that he is a good candidate for a heart attack (when he has very few risk factors).

Following are descriptions of some of the techniques typically used in CT.

Questioning

One of the most prominent techniques in CT is questioning. In fact, one of the most basic interventions in CT is to ask the client, "What was going through your mind right now?" when the counselor notices a change in the client's affective state (Newman & Beck, 1990). The idea is that emotions are good indicators of the presence of automatic thoughts.

Socratic questioning refers to the strategy of asking leading questions so that the client comes to the Cognitive Therapy conclusion (Beck & Emery, 2005). A favorite question of cognitive therapists is, "Where is the evidence for this thought/belief?" It is the counselor's job to devise questions that help clients alter their current views to "a state of inquisitiveness and curiosity" (Wright & Beck, 1996, p. 1021).

Six types of questions are considered effective in helping clients test automatic thoughts (J. S. Beck, 1995, p. 109): "(1) What is the evidence? (2) Is there an alternative explanation? (3) What is the worst that could happen? Could I live through it? What is the best that could happen? What is 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) What would I tell _____ [a friend] if he or she was in the same situation?"

Mia asks Steve about what goes through his head when he gets mad at work. He reports, after some consideration, that sometimes he thinks, "they are mean" and "they hate me." At other times he thinks, "I screwed up" or "I can't do this job." Mia asks Steve what evidence he has that others hate him and are mean. He replies that they criticize his performance on the job. "Do you deserve the criticism?" asks Mia. "Well, yes," Steve replies, "I did screw up." "But does that automatically mean that they hate you?" Mia asks. "Well, I guess not," replies Steve. Mia then follows with "What's the effect of thinking that people at work are mean and hate you?" Steve acknowledges that his belief leads to easily triggered anger and subsequent "immature" behavior. Afterward, he finds himself depressed.

Downward Arrow

This technique is used to identify core beliefs. It is so-named because the therapist starts by examining thoughts relatively close to the "surface" and proceeds downward to core beliefs. First, a key automatic thought is identified that the counselor thinks is related to a core belief. The counselor then asks the client what this thought means, assuming it is true. Repeating this question for each client response will eventually lead to the core belief. Judith Beck (1995) noted that asking the client what the thought means *to* the client often leads to an intermediate belief, whereas asking what the thought means *about* the client leads to a core belief (p. 145).

Mia asks Steve to examine the belief that his parents think he is an alcoholic manic-depressive. She directs Steve to assume this is true and asks him what it means to him. Steve divulges that it means that his parents think badly of him. "OK, so assume that's true," Mia says, "What does that mean, that they might think badly of you?" Steve replies, "Well, it means that I am a failure as a person and worthless." Mia and Steve have identified a dysfunctional core belief or schema.

Thought Recording

Cognitive therapists almost always instruct clients in some form of thought recording (Wright & Beck, 1996). One commonly used instrument is the Dysfunctional Thoughts Record (DTR), which is shown in Table 10.4 (J. S. Beck, 1995). The counselor gives the client the DTR to take home, asking him to record various occurrences of ATs between counseling sessions. At the next session, counselor and client review the DTR, evaluate the client's responses to the ATs, and work on alternatives, if necessary.

Steve records his automatic thought that occurred after disagreeing with a coworker, Sue. Thinking "she hates me" leads to Steve's sadness. Mia and Steve review the form and find that Steve did not really convince himself with the adaptive response he devised, although he did feel less sad. Mia and Steve work to find a response that will help Steve further reduce the sadness or eliminate it entirely.

Behavioral Experiments

Behavioral experiments are assignments that are tailored to a specific belief. The therapist and client design a task or activity that challenges a faulty cognition (Beck & Emery, 2005). For example, Nancy, who believes that she has no fun in life, is asked to pick one activity that might possibly be fun, such as going to the zoo. She is asked to go to the zoo

TABLE 10.4
STEVE'S DYSFUNCTIONAL THOUGHT RECORD

Date/Time	Situation	Automatic Thoughts	Emotions	Adaptive Response	Outcome
	1. What event, image, or recollection led to the emotion?	1. What thoughts/ images?	1. What emotion did you feel?	1. (optional) What cognitive distortion did you make?	1. How much do you now believe your AT?
	2. Any physical sensations?	2. How much did you believe them?	2. How intense? (0–100%)	2. Use questions at bottom to form a response to the AT.	2. What emotions do you feel now? How intense? (0–100%)
				3. How much do you believe the response? (0–100%)	3. What will you do (or did you do)?
6/19/06	1. Disagreed with coworker	1. She hates me	1. Sad	1. Magnification? Overgeneralization? (not sure)	1. 40%
			2. 80%	2. Just because I disagreed with Sue doesn't necessarily mean she hates me	2. Still sad, but less
				3. 70%	3. Nothing

Questions to consider about AT: (1) What is the evidence that the AT is true? (2) Is there an alternative explanation? (3) What's the worst that could happen? (4) What's the effect of my believing the AT? (5) What should I do about it? (6) If _____ [a friend] was in the situation, what would I tell him/her?

From *Cognitive Therapy: Basics and Beyond* (p. 126) by J. S. Beck, 1995, New York: Guilford. © 1995 by The Guilford Press. Adapted with permission.

and report what happens. If she has fun, then her belief is disconfirmed. If she doesn't have any fun, then the thoughts she has at the zoo can be examined.

Mia and Steve develop a behavioral experiment for him that tests his belief that "it's no use; I can't do anything right." They identify something that would be "right"—he could negotiate a conflict in his living situation without getting so angry that he "blows up." For example, Steve wants to be able to see a certain show on TV, but is afraid to ask the others in the residence about it (the TV is communal). Mia and Steve work on strategies to help Steve ask this question.

ACTIVITY SCHEDULING

When clients are very depressed or for other reasons have low motivation, it is often helpful to have them create a daily schedule, on paper, to follow between therapy sessions (Newman & Beck, 1990). The counselor may ask the client to simply keep a record of daily activities at first to establish baseline information. After reviewing these data, the client and

counselor then work together to fill in the blocks of an activity chart, which lists the days of the week across the top and hours along the left side (J. S. Beck, 1995). Part of recording daily activities often involves rating each on a scale of 1 to 10 for mastery and pleasure (Beck & Weishaar, 2005). This technique is sometimes called mastery and pleasure therapy, particularly when activities are developed to create successful outcomes (Beck, 1976).

Because Steve is in the work-therapy program, he does not need to activity schedule during the week. However, he does admit that he has difficulties on the weekends. Mia and Steve develop a schedule for Saturdays that includes important errands that Steve would like to accomplish (go shopping, for example) along with some fun activities (watch a Little League baseball game). Specific times are set up for the activities, and Steve is to record his completion of each, along with ratings of mastery and pleasure.

Graded Tasks

When a client faces what seems to be an overwhelming task, the counselor and client can work to make it less intimidating by breaking it down into smaller steps. This procedure is called creating a graded task assignment (Beck & Weishaar, 2005). Concrete steps are formulated to reach the agreed-upon goal, and the client then works on the steps one at a time, focusing on the achievement of each. The first steps devised should be relatively easy so that the client is not overwhelmed and, ideally, experiences some initial success (Freeman, Schrodt, Gilson, & Ludgate, 1993). In fact, Beck also called this technique success therapy (Beck, 1976, p. 272). Self- and therapist reinforcement are important in this process.

Mia and Steve examine Steve's goal to get a job. Because this is an intimidating task for Steve, they break it down into a number of steps using the graded task approach. The first step is to have Steve read a good reference book on job searching. Next, Steve constructs his resume and brings it to Mia for review. Steve decides he wants to go into the restaurant industry, so he and Mia problem solve about how to get a job there given his lack of background. They decide that he should have lunch in a moderately priced restaurant and try to engage in some chitchat with one or two staff members about how to get a job. These steps are just a beginning, but Steve and Mia write them down, and as he tackles each, they examine his cognitions about them. Mia is careful to praise Steve when he accomplishes his task for the week, and she makes sure that Steve does something nice for himself, too.

Assertiveness Training

Borrowed from behaviorism, assertiveness training involves teaching clients skills that support their rights without violating the rights of others. Role-play is frequently used in assertiveness training, along with simple, concrete teaching of information about rights and responsibility.

Mia teaches Steve about assertive behavior. She suggests that he read a book on assertiveness training. Together, Mia and Steve decide that assertiveness training is in order for Steve because it should help his relationships at work and in the residential facility. He notes that his immature behavior is not assertive because it is either passive (he walks out) or aggressive

(he gets angry and yells). They generate a list of problem situations and examine Steve's thoughts, feelings, and behaviors while in the situations. They then generate alternative assertive behaviors to replace Steve's previously passive or aggressive ones. Mia helps Steve rehearse these new behaviors in session.

Problem Solving

Problem-solving techniques involve identifying and clarifying the problem, generating alternatives, evaluating the alternatives, implementing an alternative, and then assessing the utility of the new approach (Newman & Beck, 1990). In CT, this approach is often used to evaluate dysfunctional beliefs, such as when the benefits and costs of maintaining a given belief are explored.

Steve and Mia problem solve around his desire to remain abstinent from alcohol. One thing they decide is that when Steve gets depressed, he is likely to drink. They examine his cognitions and behaviors and devise alternative responses to use when Steve notices that he is down.

Imagery

When a client is having difficulty identifying automatic thoughts, the counselor can resort to using imagery or role-playing to vividly conjure up the problem situation (Wright & Beck, 1996). Because these techniques are likely to evoke the emotions associated with the problematic situations, they should help the client identify cognitions associated with the feelings. The **turn-off technique** can be used to help clients learn that they can control images (Beck & Emery, 2005). In this technique, the therapist and client think up a way to sharply disrupt the image, such as clapping his hands or blowing a whistle. Images can also facilitate the development of adaptive cognitions, and then the client can practice this in session or as homework.

Steve wants to work on feeling good about his interactions with his parents. He is terrified to contact his mother because he has heard that she has "disowned" him. Mia helps Steve imagine making a phone call to his mom, and they examine his thoughts and responses.

Role Playing and Other Behaviorally-Oriented Techniques

Also known as behavioral rehearsal, role playing can be used to help the client practice behaviors useful in social situations (Beck & Weishaar, 2005). Exposure is also used in CT, particularly with clients who present with anxiety-related problems (Beck & Emery, 2005). Typically, a graded approach is used, in which the client takes baby steps toward the feared situation or object. Self-instruction can be added to exposure: the client uses a prepared set of self-coaching statements to help the client cope with the stress of confronting the feared situation (Beck & Emery, 2005).

Mia and Steve role-play the telephone call to his mother. Mia plays mom; Steve practices what he will say, using adaptive thoughts rather than negative automatic ones.

EVALUATION OF THE THEORY

Cognitive Therapy has evoked criticism from many fronts. Early on, it was attacked by the behaviorists and psychoanalysts alike (Arnkoff & Glass, 1995). Behaviorists thought that cognition was superfluous to behavior change. According to Meichenbaum (1993), a subgroup of behavioral therapists threatened to throw the "cognitivists" out of the Association for Advancement Behavior Therapy. Psychoanalytic folk tend to dismiss CT as surface oriented, dealing with symptoms rather than the important issues. Behaviorists, at least, seem to have changed their opinions; in a 1990 survey 69% of the members of the American Association of Behavior Therapy reported that they use cognitive techniques (Craighead, 1990).

On first examination, CT appears relatively simple to use. It provides clear explanations for problems and allows the use of a wide variety of techniques (Arnkoff & Glass, 1995). However, counselors may find that identifying cognitions, particularly automatic thoughts, is not as simple as it may seem.

Paradoxically, a common criticism of CT is that it is too simple and mechanistic. It is said to ignore the client's emotions and history in favor of the client's thinking. Others accuse CT theory of ignoring environmental influences and the effects of individuals' attempts to cope with their situations (Coyne & Gotlib, 1986). CT theorists respond to these criticisms by pointing out that the client's early experiences are seen as very important in determining schemas and core beliefs (Beck et al., 2004; Beck & Weishaar, 2005). The relative sensitivity of modes to activation (which determines the degree of dysfunction) is also linked to early experience.

A strength of CT is that Beck and his associates have continually evaluated, modified, and advanced the theory. Loads of outcome research supports this approach (for a recent summary, see Beck, 2005 or Leahy, 2004). The modal perspective is an interesting addition to CT theory, although it makes the theory sound a lot more psychoanalytic. I personally find the addition of recent constructs such as modes, personality types, and so on, confusing because it is not clear how they relate to earlier CT theory. Depending on which source you consult, the modes and personality types might or might not be discussed. For example, J. S. Beck is silent about modal processing. Also, the specific modes hypothesized by the theory seem to change depending upon what source you consult.

QUALITIES OF THE THEORY

Precision and Testability. To his credit, Beck was one of the leaders in the development of treatment manuals; Beck, Rush, and colleagues (1979) presented the first treatment manual for CT (it should come as no surprise that the behaviorists developed the very first manuals). The presence of treatment manuals makes the testing of CT outcome easier and more valid. There is a massive amount of data that tests the outcome of CT, but despite the theory's apparent simplicity, the testability of CT is debated. Coyne and Gotlib (1986) argued that the CT constructs were difficult to test, calling them "slippery and indeterminate" (1986, p. 697). In addition, Oei and Free (1995) suggested that measurement problems plagued CT theory in that the standard measures of cognitive dysfunction (the ATQ and the DAS) might be assessing general psychological dysfunction rather than cognitive distortion specifically. Hayes, Luoma, Bond, Masuda, and Lillis (2006) maintained that although there

is much research on CT, the link between cognitive change and improvement is not well established (more on this later).

Empirical Validity. Cognitive Therapy is perhaps the most well-researched counseling approach in existence, with an overwhelming amount of empirical support for its effectiveness with a variety of client problems (Beck, 2005; Leahy, 2004). However, evidence for the theoretical assumptions and structure is less impressive.

Research Support

Outcome Research. Outcome research has uniformly supported CT. Hundreds of studies have examined the efficacy of CT, probably because it was one of the earliest manualized treatments and also because good outcome measures exist, particularly for depression (e.g., the Beck Depression Inventory and the Hamilton Depression Rating Scale).

Numerous studies have tested the efficacy of CT with various diagnostic categories. For the most part, CT has been found to be as effective as other treatments, more effective than no-treatment controls, and in some cases more effective than placebo control groups. Not surprisingly, a significant amount of this research has focused on depression. One of the best known trials of CT is the NIMH treatment of depression study, summarized in Chapter 1. As you may recall, the results of the NIMH study were disappointing because the treatment approaches (CT and interpersonal therapy) did not produce improvement relative to the placebo group.

Meta-analytic studies have generally supported the efficacy of CT. Butler, Chapman, Forman, and Beck (2006) reviewed 16 meta-analyses on outcome studies of cognitive-behavioral therapy (CBT). They found that CBT was effective over a wide range of dysfunction, including depression, anxiety, posttraumatic stress disorder, anger, chronic pain, and marital distress. Dobson (1989) conducted a meta-analysis of 28 studies of depression, each of which used Beck's treatment manual and the Beck Depression Inventory (BDI) as the outcome measure. When compared to no-treatment or wait-list control groups, CT achieved an effect size of 2.15, which is large by psychotherapy outcome standards and indicates that the average client in CT was better off than 98% of the control clients. Dobson also reported that CT was more effective than behavior therapy or pharmacotherapy, although the effect sizes were much smaller (about 0.50). A comparison of CT and placebo treatment was not included in this study. Reinecke, Ryan, and DuBois (1998) found that CT was effective in interventions for depression among adolescent clients.

Because depression is commonly treated with antidepressant medication, investigators in this area have been interested in the relative efficacy of CT and drug treatment. A meta-analysis addressing this question examined studies published between 1977 and 1997, including 48 trials consisting of 2,765 clients (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998). In all of these studies, the outcome measure was the BDI. Gloaguen and colleagues found that CT produced better results than waiting lists, placebo treatments, and antidepressant drug treatment. Comparisons with a set of "other" therapies also showed CT to be more effective. However, CT was found to produce about the same amount of change as Behavior Therapy.

Studies documenting the superiority of CT to other approaches, however, must be viewed with caution. Some evidence suggests that studies conduced by proponents of a given approach tend to show results favorable to that approach. Robinson, Berman, and Neimeyer (1990) examined the effects of investigator allegiance and found this state of affairs true for studies of depression. When allegiance was *not* controlled, cognitive, cognitive behavioral, and behavioral approaches appeared to produce better outcomes than other approaches (labeled *general verbal therapy* by these investigators). However, when investigator allegiance was controlled, these effects disappeared. In addition, as a group, all therapies did not significantly improve on the effects of placebo treatments. When comparing psychotherapy to pharmacological treatments, Robinson and colleagues also found investigator effects: an initial apparent superiority of psychotherapy disappeared once allegiance effects were taken into account. Gaffan, Tsaousis, and Kemp-Wheeler (1995) replicated this effect, but found less evidence of allegiance effects in a set of more recently published studies that were not included in Robinson et al.'s analyses. Similarly, Wampold and colleagues (1997) meta-analyzed 277 treatment comparisons, specifically testing for variations in efficacy among theoretical orientations, and also found no significant differences.

Although fewer studies are available, CT appears to be effective for anxiety disorders, including generalized anxiety, panic disorder, agoraphobia, and social phobia (Chambless & Gillis, 1993; Clark & Ehlers, 1993; Gould, Buckminster, Pollack, Otto, & Yap, 1997; Wenzel, Sharp, Brown, Greenberg, & Beck, 2006). However, it should be noted that in many cases these trials involved treatments that combined pure CT with standard behavioral techniques, such as relaxation training, desensitization, or biofeedback. It is not clear that CT is effective for these disorders (particularly agoraphobia) on its own, nor that it is superior to behavioral approaches. An interesting finding from Wenzel, Sharp, Brown, et al. (2006) was that beliefs specific to panic decreased over CT treatment, which would seem to partially support the cognitive conceptualization of anxiety disorders proposed by Beck and Emery (2005; 1985). Earlier, Chambless and Gillis (1993) had found similar results, but also noted that cognitive changes are produced by approaches other than CT, so these results can not be construed as robust support for CT theory.

Beck and his colleagues are also very interested in suicidal behavior (Beck, 2005). An example of a recent study that assessed the effects of CT in reducing repeated suicide attempts was reported by Brown et al. (2005). In this randomized controlled trial of CT and treatment as usual (TAU) with clients who had been evaluated at a hospital for attempted suicide, those who received CT were less likely to reattempt and had lower rates of self-reported depression at a 6-month follow-up compared to the TAU clients. CT clients also reported less hopelessness than the TAU clients. Although this study attests to the effectiveness of CT, only cautious conclusions about the relative superiority of CT over TAU can be drawn, however, because of the differences in the ways that CT and TAU are administered. Chapter 1 discusses some of the issues involved in TAU-treatment comparisons.

Studies of CT with a wide range of diagnostic categories have been reported. Abramowitz (1997) reviewed interventions for Obsessive Compulsive Disorder (OCD) and concluded that CT was found to be as effective as the behavioral treatment exposure and response prevention (ERP), considered to be the "gold standard" for OCD. In a few studies, CT was found to be superior to ERP, leading Abramowitz to speculate that both approaches lead to the disconfirmation of dysfunctional beliefs associated with OCD.

Clark (2004) opined that the results comparing ERP and CT were inconclusive, writing "at this time, there is no evidence that adding a cognitive component to ERP produces significantly more symptomatic improvement than ERP alone" (p. 175). However, Clark maintains that there may be some subtypes of OCD that respond better to CT than ERP (e.g., obsessional ruminative) but comparative data are scarce. Similarly, Pretzer and Beck (2004) summarized the research on the effectiveness of CT for clients diagnosed as personality disordered, and concluded that positive evidence existed. In one such study, Brown et al. (2004) found that CT was effective for clients diagnosed as borderline personality disorder in an open trial study (i.e., not a randomized clinical trial). Rector (2004) presents evidence that CT is helpful in treating schizophrenia.

Jamison and Scogin (1995) took an interesting approach when they tested the effectiveness of cognitive bibliotherapy with adults. Participants read David Burns' book *Feeling Good* (1980). Half of the participants served in a delayed bibliotherapy group as controls. Using multiple outcome measures (including the BDI and the observer-rated Hamilton Rating Scale for Depression), these investigators demonstrated that therapists are not absolutely necessary! Moreover, the significant changes in depression observed at posttest were maintained at a 3-month follow-up.

Jakes and Rhodes (2003) reported on an interesting small N study of solution focused and cognitive-behavioral strategies with clients who had delusions. Five clients were intensively studied at baseline (no treatment) and as they were then treated with a solution focused and 2 CT interventions (Schema-Focused Cognitive Therapy and Cognitive Therapy focused on challenging the delusion) in that order. They observed that these clients (who were diagnosed with chronic psychosis as well as delusion for at least 1 year) responded positively to treatment in terms of decrease in negative beliefs about the self, as would be predicted by CT theory. However, because this was a multiple case study design, we must be cautious in drawing causal inferences from its results.

Research has also looked at whether CT helps clients retain the gains made in counseling. Hollon, Shelton, and Davis (1993) reported that in four major clinical trials of CT, clients receiving CT alone or in combination with antidepressants showed lower rates of relapse (i.e., return of symptoms) than those treated with psychopharmacological methods only. Hensley, Nadiga, and Uhlenhuth (2004) compared 5 trials of the long-term effects of CT vs. antidepressant medication (tricyclic antidepressants), finding that CT was superior in terms of preventing relapse. van Oppen et al. (2005) found that clients diagnosed as Obsessive Compulsive Disorder maintained their outcomes 5 years after treatment, but there was no difference between groups receiving CT and exposure treatment alone and those receiving psychological treatment plus antidepressant medication. However, they cautioned that because there are very few good studies of the long-term effects of CT and other therapies, strong statements about prevention effects associated with CT should be avoided at present.

Theory-Testing Research. Overall, research support for the validity of CT theory is mixed. Much of the controversy has focused on the CT model of depression. In the 1980s Coyne and Gotlib (1983, 1986) declared that the evidence for the causal role of cognitions in depression was unconvincing, and they criticized CT theory for its neglect of environmental factors and individual coping strategies. They added that "the modal depressed patient is probably a woman with marital difficulties, and glib attempts to

reduce her problems to a matter of distorted cognitions have potentially pernicious social implications" (1986, pp. 703–704).

Haaga, Dyck, and Ernst (1991) also reviewed the evidence relevant to the CT theory of depression and distinguished between CT's *descriptive* theory of depression (that depressives are a certain way) and its *causal* theory of depression (that cognitions cause depression). Depressed individuals, according to theory, are thought to display more negativity, which involves their views of self, the world, and the future (the cognitive triad), as well as other biases or distortions in information processing when compared to nondepressed people. In addition, CT theory predicts that positive thoughts are practically nonexistent in depressed individuals. Further, the cognitive triad should be evident in all types of depression, and in all depressed people. The degree of negative thinking should be positively associated with the severity of noncognitive depressive features (e.g., somatic symptoms, depressed mood). Finally, the cognitive specificity hypothesis implies that depressed individuals should show different cognitive patterns than individuals displaying other types of psychological dysfunction.

In reviewing evidence relevant to the descriptive model, Haaga and colleagues (1991) found support for the negativity hypothesis, the cognitive triad, and bias in information processing. Individuals who are depressed seem to display more negative thoughts than people who are not depressed do, and this effect extends to views of the self, world, and future. Evidence for the other hypotheses was weaker and often was compromised by methodological problems or theoretical fuzziness. For instance, the elements of the cognitive triad seem to be overlapping—the negative view of the world seems to emphasize self-related aspects.

Evidence for the causal model of CT (that cognitions cause depression) is less convincing (Bieling & Kuyken, 2003; Hayes et al., 2006). Controversy has long been evident, and still is, around the issues of what is generally known as the diathesis-stress model, which is the fancy name for the idea that both cognitive vulnerability (i.e., activation of negative cognitive systems) and an external stressor are required to produce dysfunction. Early on, Hagga and colleagues (1991) asserted that no single study has completely tested the proposed relationships among personality dimensions (sociotrophy and autonomy), dysfunctional beliefs, stress, and depression. Haaga and colleagues concluded, "We thus find little convincing support for causal hypotheses of cognitive theory, but at the same time, it would be premature to abandon them" (p. 231). More recently, Zuroff, Mongrain, and Santor (2004) reviewed the literature specific to sociotrophy and autonomy, and concluded that the picture was less bleak, and that there was merit in continuing to investigate the diathesis-stress model. An attempt to perform such research is represented by Dozois and Backs-Dermott's (2000) study of sociotrophy and negative outcomes. This was an experimental study in which participants listened to an audiotape depicting an interpersonal rejection and then completed checklists of self-relevant adjectives and a reaction time task. Consistent with predictions, participants high in sociotrophy showed more negative reactions than those low in sociotrophy. Studying more generalized dysfunctional attitudes in an experimental design, Abela and D'Alessandro (2003) found some support for the model in that such attitudes predicted depression for students who had received negative feedback on a college admissions decision. Although the experimental nature of these designs appears to be a far cry from actual depressive processes in the "real world,"

nonetheless the study yields some support for CT theory. Using a longitudinal design, Grazioli and Terry (2000) found similar results in studying postpartum depression.

Oei and Free (1995) looked at the role of outcome research in validating CT theory more closely and found that cognitive change occurs in depressed individuals who engage in CT therapy. However, this evidence is not considered as particularly supportive of CT theory because the same kind of change is documented among individuals in other psychological therapies as well as in psychopharmacological treatment and wait-list groups. In explaining these findings, Oei and Free offered the circular process model, which suggests that the changes in biological processes induced by drug treatment create changes in cognition (reduced negative thinking). The process is reversed in verbal therapy; change in cognition leads to biochemical change. Even if research data existed that supported the second hypothesis, the fact that these changes occur in other therapies still suggests a general process found in counseling rather than one specific to CT theory. In contrast, Beevers and Miller (2005) used a longitudinal design, and found that the relationship between cognitions and depressions was weaker for clients who had completed Cognitive Therapy than family therapy (in both cases, pharmacological interventions were used).

Recent research in treatment contexts also provides some evidence for the hypothesized links between cognition and dysfunction. Wenzel, Sharp, Sokol, and Beck (2006) demonstrated that individuals completing a trial of CT for panic disorder differed in the degree of attentional fixation depending on their treatment outcomes. Clients who still met the criteria for panic disorder at the end of treatment showed higher levels of fixation than those who no longer could be diagnosed. Because attentional fixation is considered to be a theoretically predicted element of panic disorder, this research can be seen as supportive of CT. However, this study is probably subject to the same criticisms that Oei and Free offered. In a study of postpartum women, Evans, Hernon, Lewis, Araya, and Wolke (2005) documented that women who had the most negative self-schemas were more likely to become depressed after childbirth when compared to women with less negative schemas. Once again, because of the design of this study, causal conclusions are risky, although the longitudinal design makes it somewhat more convincing than would a cross-sectional method.

In summary, research generally supports the effectiveness of CT with a wide variety of clients. However, claims of its superiority to other treatments are less convincing. Although some evidence has suggested support for the theoretical propositions of CT, it is extremely difficult to really test the underlying assumptions of the CT model.

ISSUES OF INDIVIDUAL AND CULTURAL DIVERSITY

Hoffman (2006) noted that an individual's culture will influence how he or she perceives the world, including one's own behavior, and thus, interventions should take this into account. Drawing on literature from social psychology, Hoffman suggests that individuals from non-Western culture are more likely to accept contradictory thoughts or ideas than are westerners. For example, explaining anxiety as worry about an upcoming job-related presentation rather than as a sign of an impending heart attack might be acceptable to a client from a Western culture. This client could pick the first rather than the second explanation. In contrast, a non-Western client might be much more comfortable in holding

both explanations simultaneously. Differences such as this one clearly could have some important implications for cognitive restructuring efforts.

Other Western-based principles of CT conflict with the values and norms of other cultures. CT assumes that the individual is largely responsible for his own fate; this individualistic outlook may clash with collectivistic values such as those found in some Asian, Hispanic/Latino/Latina, or American Indian cultures. Clients who are highly spiritual may not respond well to the emphasis on individual choice and control because they believe in the influence of higher powers in human activity. At the same time, Ivey, D'Andrea, Ivey, and Simek-Morgan (2002) argued that the structure and clarity of CT may appeal to minority clients. Chen's (1995) comments about the consistency of REBT values (emphasis on logical thinking, cognitive control of emotion, counselor as teacher, and the active directive nature of therapy) and Chinese culture probably apply to CT as well. There seems to be much agreement that CT can be adapted to a wide range of client diversity (Hays & Iwamasa, 2006).

Scorzelli and Reinke-Scorzelli (1994) collected data that illustrated the problem with the individualistic stance of CT. They surveyed a group of graduate students in India about the fit of CT (REBT and CT) with their culture. Most of the students were female and identified Hindusim as their primary religion. About 87% of these students judged that CT was inconsistent with their cultural values, most prominently with the belief in karma, that one's destiny is fixed. These students also saw CT as conflicting with values such as obedience to family and other cultural values, including sex role expectations.

In contrast, Wong, Kim, Zane, Kim, and Huang (2003) found that for clients who were identified with Asian culture, CT was viewed as more credible than time-limited psychodynamic therapy. In this study, Asian clients who varied in ethnic identity were exposed to treatment rationales for depression based on the two approaches. Asian participants who identified more strongly with Western culture did not differ in their reactions to the two rationales, whereas those lower in Western identity responded more favorably to the CT rationale. Also, individuals with more independent self-construals (as compared to those who were more interdependent) evaluated CT more favorably. Wong and colleagues suggested that the emphasis on individual control in CT was responsible for both of these effects. Clients who are less Anglo in their orientations (presumably more identified with Asian culture) prefer interventions that stress individual adaptation to unchanging extrapersonal factors. Independence, which is thought to be relatively unrelated to cultural identity, would fit well with the individual focus of CT.

Davis and Padesky (1989) suggested that the collaborative nature of the CT relationship promoted the egalitarianism that is important when working with female clients. Encouraging the client to evaluate therapy sessions, set the counseling agenda, and giving the client the opportunity to discuss diagnoses, should empower women who may have experienced cultural pressure to be passive and submissive to men. On the other hand, the presentation of the counselor as an expert, almost in the doctor–patient mode, would seem to contradict the egalitarian spirit endorsed by Davis and Padesky.

Clients who are stigmatized by society may also develop negative self-schemas as a result of cultural pressure. Individuals who are gay, lesbian, bisexual, or transgender (GLBT) or members of groups who have been the subject of prejudice or discrimination would seem particularly vulnerable in this respect. Although the sensitive cognitive therapist could help

modify a client's self-schema, this intervention would not immunize the client from social pressures (Davis & Padesky, 1989). The therapist would also have to direct attention toward helping the client deal with cultural disapproval.

In general, the neglect of environmental factors and influences in CT theory may be problematic when working with culturally and individually diverse individuals. People who have experienced prejudice, discrimination, and oppression might have more difficulty locating the sources of their discomfort solely in their cognitive processes.

THE CASE STUDY

Aspects of Steve's presentation fit well with a CT approach, and others do not. Steve is a Caucasian male, so cultural issues may not be paramount. The classic client for CT is one with prominent depression. Although Steve does report some depression, it does not seem severe. However, CT has been applied to a variety of client dysfunctions, including substance abuse, which is clearly a central issue for Steve. In fact, Steve is not reporting a lot of affect in general and seems to be more focused on changing his life situation. Thus, the problem-focused CT approach works well for him.

Beck's modal view describes Steve's manic behavior as hyperactivation of the self-enhancement mode. Thus, his diagnosis of bipolar disorder is captured by activity in the loss and self-enhancement modes. Mia hypothesized that his victim mode was also active, which raises the question about how many modes are likely to be sensitized for a given person.

Summary

CT proposes the cognitive model of therapy: our behaviors and feelings are a result of our cognitive process and structures. Specifically, clients' automatic thoughts, intermediate beliefs, and core schemas are associated with depression, anxiety, and a variety of other kinds of psychological dysfunction. Automatic thoughts are brief, telegraphic statements or images that are related to core beliefs or schemas. Beliefs and schemas are more elaborate structures that sometimes function outside of our everyday awareness. Schemas are complex cognitive structures that aid in the organization of experience and can influence the ways we interpret events. One important schema is the depressogenic schema, which features the cognitive triad of a negative view of self, world, and future.

Cognitive therapists help clients by engaging them in collaborative empiricism—the process of examining their thoughts, assumptions, and beliefs as hypotheses rather than truths. The cognitive therapist is an expert and the client a learner who is expected to take increasing responsibility for counseling as he learns the system. Both cognitive and behavioral techniques are used in CT, and clients are almost always given homework.

CT has the strength of being relatively straightforward and structured. It is probably appealing to clients who expect the therapist to be an expert. The efficacy of CT is well established; however, the support for the theoretical predictions of CT is less impressive.

Concerns can also be raised that CT's emphasis on internal process and individual responsibility may clash with the views and values of clients who are from non-Western European cultures, female, or of GLBT orientation or in other ways diverse (physically challenged, for instance). However, the collaborative relationship found in CT can be empowering to clients who are members of groups that have been historically subject to oppression.

Visit Chapter 10 on the Companion Website at **www.prenhall.com/murdock** for chapter-specific resources and self-assessments.

For ease of expression, throughout this chapter references to Beck (without initials) will refer to Aaron Beck's authorship.