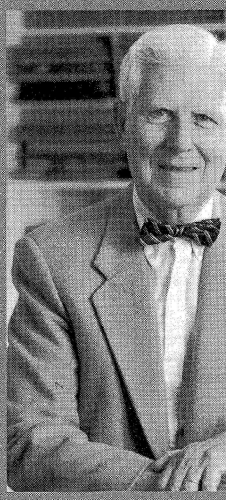

Courtesy of Aaron T. Beck, PhD, University of Pennsylvania

Aaron T. Beck

8 COGNITIVE THERAPY

Aaron T. Beck and Marjorie E. Weishaar

OVERVIEW

Cognitive therapy is based on a theory of personality that maintains that peopl to life events through a combination of cognitive, affective, motivational, and b responses. These responses are based in human evolution and individual lea tory. The cognitive system deals with the way individuals perceive, interpret, a meanings to events. It interacts with the other affective, motivational, and pl cal systems to process information from the physical and social environmen respond accordingly. Sometimes responses are maladaptive because of misper misinterpretations, or dysfunctional, idiosyncratic interpretations of situations.

Cognitive therapy aims to adjust information processing and initiate positive all systems by acting through the cognitive system. In a collaborative process, the and patient examine the patient's beliefs about himself or herself, other pe the world. The patient's maladaptive conclusions are treated as testable hy Behavioral experiments and verbal procedures are used to examine alternat pretations and to generate contradictory evidence that supports more adapti and leads to therapeutic change.

forthe survival of any organism.If WC did not have a functional apparatus fortaking in relevantinformation from the environment, synthesizing it, and formulating a plan of action on the basis ofthis synthesis, WC WOuld soon die or be killed.

Each systCIIIL involved in surviva工@cognitive, behavioral, affective, and motivational— composed of structures known as schemas. Cognitive schemas contain people s perceptions ofthemselves and others and oftheir goals and expectations, memories,fantasies, and previous learning. These greatly influence,if not control,the processing ofinformation.

In various psychopathological conditions such as anxiety disorders, depressive disorders, mania, paranoid states, obsessive-compulsive neuroses, and others, a specific bias affects hOW the person incorporates nCW information. Thus, a depressed person has a negative bias,including a negative viCW of self, WOrld, and future.In anxiety,there is a systematic bias or cognitive shifttoward selectively interpreting themes of danger.In paranoid conditions,the dominant shiftis toward indiscriminate attributions of abuse or interference, and in mania the shiftis toward exaggerated interpretations of personal gain.

Contributing to these shifts are certain specific attitudes or core beliefs that predis pose people underthe influence of certain life situations to interprettheir experiences in a biased way. These are known as cognitive vulnerabilities. For example, a person WIIo has the beliefthat any minorloss represents a major deprivation may react catastrophically to even the smallestloss. A person WトO feels vulnerable to sudden death may overinterpret normal body sensations as signs ofimpending death and have a panic attack.

Previously, cognitive theory emphasized a linearrelationship between the activation of cognitive schemas and changes in the other systems;thatis, cognitions (beliefs and assumptions)triggered affect, motivation, and behavior. Current cognitive theory, benefiting from recent developments in clinical, evolutionary, and cognitive psychology, views all systems as acting together as a mode. Modes are networks of cognitive, affective, motivational, and behavioral schemas that compose personality and interpret ongoing situations. Some modes, such as the anxiety mode, are primal, meaning they are universal and tied to survival. Other modes, such as conversing or studying, are minor and under conscious control. Although primal modes are thoughtto have been adaptive in an evolutionary sense,individuals may find them maladaptive in everyday life WIIen they are triggered by misperceptions or overreactions. Even personality disorders may be viewed as exaggerated versions offormerly adaptive strategies.In personality disorders, primal modes are operational almost continuously.

Primal modes include primalthinking, WIIich is rigid, absolute, automatic, and biased. Nevertheless, conscious intentions can override primalthinking and make it more flexible. Automatic and reflexive responses can be replaced by deliberate thinking, conscious goals, problem solving, and long-teCIIIL planning.In cognitive therapy, a thorough understanding ofthe mode and allits integral systems is part ofthe case conceptualization. This approach to therapy teaches patients to use conscious controlto recognize and override maladaptive responses.

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The overall strategies of cognitive therapy involve primarily a collaborative enterprise between the patient and the therapistto explore dysfunctionalinterpretations and try to modify them. This collaborative empiricism views the patient as a practical scientist WLo lives by interpreting stimuli but WトO has been temporarily thwarted by his or her own information-gathering and integrating apparatus (cf. Kelly,1955).

The second strategy, guided discovery,is directed toward discovering WトatthreadS run through the patient's present misperceptions and beliefs and linking thCIIIJ to analogous experiences in the past. Thus,the therapist and patient collaboratively WCave a tapestry thattells the story ofthe development ofthe patient's disorder.

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in an Armenian cooking class WHere the teacher, IVHo did not speak English WCll,taught mainly by demonstration. But as hard as he tried, he could never quite make his dishes taste as good as hers. He decided to observe his teacher more carefully, and in one lesson noted that VHen she finished her preparation she handed her dish to her assistant, who took itinto the kitchen to place into the oven. He observed the assistant and was astounded, and edified,to note thatthat before throwing the dish in the oven, she threw in handfuls of various spices that struck herfancy. These "thrOW-ins" he likened to the interactions thattherapists have with their patients, WHich, because they are not conceptualized within theirtheoretical "recipe," go unnoticed. Perhaps, however,these off-the-record extras are the criticalingredients. And perhaps these throw-ins referto the shared issues of human existence@Ln short,to existential psychotherapy.

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Existentialists regard people as meaning-making beings WIIo are both subjects of experience and objects of self-reflection. We are mortal creatures WHo, because WC are self aware, know that we are mortal. Yetitis only in reflecting on our mortality that WC can learn hOW to live. People ask themselves questions concerning their being: Who am I? Is life WOrth living? Does it have a meaning? How can Irealize my humanity? Existentialists hold that ultimately, each of us must come to terms with these questions and each o us is responsible for WLo WC are and TELHat WC become.

Because existentialists are sensitive to the ways in WHich theories may dehumani people and renderthem as objects, authentic experience takes precedence over artificial explanations. When experiences are molded into some preexisting theoretical model, they lose their authenticity and become disconnected from the individual WHo experienced them. Existential psychotherapists,then,focus on the subjectivity of experience ratherthan "objective" diagnostic categories.

The Ultimate Concerns

Issues such as "choice," "responsibility," "mortality," or "purpose in life" are ones th alltherapists suspect are central concerns of patients. More and more, patients come to therapy with vague complaints aboutloss of purpose or meaning. Butitis often more comfortable forthe therapistto reframe these concerns into symptoms and to talk with patients about medication orto prescribe manualized exercises than to engage genuinely with them as they search for meaning in life. Many diagnosable presenting "symptoms" may mask existential crises.

The existential dilemma ensues from the existentialreality that although VC crave persistin our being, WC are finite creatures;that WC are thrown alone into existence wit out a predestined life structure and destiny;that each of us must decide hOW to live as happily, ethically, and meaningfully as possible. Yalom defines four categories of "ulti concerns" that encompass these fundamental challenges ofthe human condition. These are freedom,isolation, meaning, and death.

Freedom

The teLLI freedom in the existential sense does notreferto politicalliberty orto the gr range of possibilities in life that come from increasing one's psychological awareness.I stead,itrefers to the idea that WC alllive in a universe withoutinherent design in WHic are the authors of our own lives. Life is groundless, and WC alone are responsible for o choices. This existentialfreedom carries with itterrifying responsibility and is always nected to dread.Itis the kind offreedom people fear so much thatthey enlist dictators,

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masters, and gods to remove the burden from them. Erich Fromm (1941) described "the lustfor submission" that accompanies the effortto escape from thatfreedom.

Ultimately, we are responsible for what we experience in and ofthe world. Responsibility is inextricably linked to freedom because we are responsible forthe sense we make of our world and for all of our actions and ourfailures to act. An appreciation of responsibility in this sense is very unsettling.If we are,in Sartre's terms, "the uncontested author" of everything that we have experienced,then our most cherished ideas, our most noble truths,the very bedrock of our convictions are all undermined by the awareness that everything in the universe is contingent. We bearthe burden of knowing that we are responsible for all of our experience.

The complementto responsibility is our will. While this concept has waned lately in the social sciences,replaced by terms such as motivation, people are still ultimately responsible forthe decisions they make. To claim that a person's behavioris explained (i.e., caused) by a certain motivation is to deny that person's responsibility for his or her actions. To abrogate such responsibility is to live inauthentically,in what Sartre has called bad faith. Because ofthe dread of our ultimate freedom, people erect a plethora of defenses, some of which give rise to psychopathology. The work oftherapy is very much aboutthe (re) assumption ofresponsibility for one's experience.Indeed,the therapeutic enterprise can be conceived of as one in which the client actively increases and embraces his or herfreedom:freedom from destructive habits,from self-imposed paralysis ofthe will, orfrom self-limiting beliefs,justto name a few.

Isolation

Individuals may be isolated from others (interpersonalisolation) orfrom parts ofthemselves (intrapersonalisolation). Butthere is a more basic form ofisolation, existential isolation,that pertains to our aloneness in the universe, which,though assuaged by connections to other human beings, yetremains. We enter and leave the world alone and while we are alive, we must always manage the tension between our wish for contact with others and our knowledge of our aloneness. Erich Fromm believed thatisolation is the primary source of anxiety.

Aloneness is differentfrom loneliness, which is also a ubiquitous issue in therapy. Loneliness results from social, geographic, and culturalfactors that supportthe breakdown ofintimacy. Or people may lack the social skills or have personality styles inimical to intimacy. But existentialisolation cuts even deeper;itis a more basic isolation thatis riveted to existence and refers to an unbridgeable gulf between oneself and others.Itis most commonly experienced in the recognition that one's death is always solitary, a common theme among poets and writers. But many people are in touch with their dread of existentialisolation when they recognize the terror offeeling thatthere may be moments when no one in the world is thinking ofthem. Or walking alone on a deserted beach in another country, one may be struck with a dreadfulthought: "Right atthis moment, no one knows where I am." If one is not being thought about by someone else,is one stillreal?

In working with people who have lost a spouse, Yalom was struck not only by their loneliness but also by the accompanying despair atliving an unobserved life—of having no one who knows whattime they come home, go to bed, or wake up. Many individuals continue a highly unsatisfying relationship precisely because they crave a life witness, a buffer againstthe experience of existentialisolation.

The professionalliterature regarding the therapist-patientrelationship abounds with discussions of encounter, genuineness, accurate empathy, positive unconditionalregard, and "I-Thou" relating. A deep sense of connection does not "solve" the problem of existentialisolation, butit provides solace. Yalom recalls one ofthe members of his cancer group who said, "I know we are each ships passing in the dark and each of us is a

Both these strategies are implemented using Socratic dialogue, a style of questio that helps uncoverthe patient's views and examines his or her adaptive and maladaptive features.

The therapy attempts to improve reality testing through continuous evaluation of sonal conclusions. The immediate goalis to shiftthe information-processing apparatus to a more "neutral" condition so that events will be evaluated in a more balanced way.

There are three major approaches to treating dysfunctional modes:(1) deactivating them,(2) modifying their content and structure, and (3) constructing more adaptive modes to neutralize them.In therapy,the first and third approaches are often accomplished simultaneously,forthe particular belief may be demonstrated to be dysfunctional and a new beliefto be more accurate or adaptive. The deactivation of a dysfunctional mode can occurthrough distraction orreassurance, butlasting change is unlikely unless a person's underlying, core beliefs are modified.

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Techniques used in cognitive therapy are directed primarily at correcting errors and biases in information processing and at modifying the core beliefs that promote faulty conclusions. The purely cognitive techniques focus on identifying and testing the patient's beliefs, exploring their origins and basis, correcting them ifthey fail an empir orlogicaltest, or problem solving. For example, some beliefs are tied to one's culture, genderrole,religion, or socioeconomic status. Therapy may be directed toward problem solving with an understanding of hOW these beliefs influence the patient.

Core beliefs are explored in a similar manner and are tested fortheir accuracy an adaptiveness. The patient WHo discovers thatthese beliefs are not accurate is encourage to try out a different set of beliefs to determine WHetherthe nCW beliefs are more accur and functional.

Cognitive therapy also uses behavioraltechniques such as skills training (e.g.,r ation, assertiveness training, social skills training),role playing, behavioralrehearsal exposure therapy.

Other Systems

Procedures used in cognitive therapy, such as identifying common themes in a patient's emotionalreactions, narratives, and imagery, are similarto the psychoanalytic method. However,in cognitive therapy the common thread is a meaning readily accessible to conscious interpretation, WIIereas in psychoanalysis the meaning is unconscious (orrepressed) and must be inferred.

Both psychodynamic psychotherapy and cognitive therapy assume that behavior can be influenced by beliefs of WHich one is notimmediately aware. However, cognitive therapy maintains thatthe thoughts contributing to a patient's distress are not deeply buried in the unconscious. Moreover,the cognitive therapist does notregard the patient's self-report as a screen for more deeply concealed ideas. Cognitive therapy focus on the linkages among symptoms, conscious beliefs, and current experiences. Psychoanalytic approaches are oriented toward repressed childhood memories and motivational constructs, such as libidinal needs and infantile sexuality.

Cognitive therapy is highly structured and usually shortterm,typically lasting from 12 to 16 weeks. The therapistis actively engaged in collaboration with the patient. Psychoanalytic therapy is long term and relatively unstructured. The analyst is largely passive. Cognitive therapy attempts to shift biased information processing through the application oflogic to dysfunctionalideas and the use of behavioral experiments to test dysfunctional beliefs. Psychoanalysis rely on free association

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and in-depth interpretations to penetrate the encapsulated unconscious residue of unresolved childhood conflicts.

Cognitive therapy and rational emotive behaviortherapy (REBT) share an emphasis on the primary importance of cognition in psychological dysfunction, and both see the task oftherapy as changing maladaptive assumptions and the stance ofthe therapist as active and directive. There are some differences, nevertheless, between these two approaches.

Cognitive therapy, using an information-processing model,is directed toward modifying the "cognitive shift" by addressing biased selection ofinformation and distorted interpretations. The shiftto normal cognitive processing is accomplished by testing the erroneous inferences thatresultfrom biased processing. Continual dis confirmation of cognitive errors, WOrking as a feedback system, gradually restores more adaptive functioning. However,the dysfunctional beliefs that contributed to the unbalanced cognitive processing in the first place also require furthertesting and invalidation.

REBT theory states that a distressed individual has irrational beliefs that contribute to irrationalthoughts and that When these are modified through confrontation,they will disappear and thedisorder will clear up. The cognitive therapist, operating from an inductive model, helps the patienttranslate interpretations and beliefs into hypotheses, which are then subjected to empiricaltesting. An REBT therapistis more inclined to use a deductive modelto point outirrational beliefs. The cognitive therapist eschews the WOrd irrationalin favor of dysfunctional because problematic beliefs are nonadaptive ratherthan irrational. They contribute to psychological disorders because they interfere with normal cognitive processing, not because they are irrational.

A profound difference between these two approaches is that cognitive therapy maintains that each disorder has its own typical cognitive content or cognitive specificity. The cognitive profiles of depression, anxiety, and panic disorder are significantly different and require substantially differenttechniques. REBT, on the other hand, does not conceptualize disorders as having cognitive themes but,rather,focuses on the "musts," "shoulds," and otherimperatives presumed to underlie all disorders.

The cognitive therapy model emphasizes the impact of cognitive deficits in psychopathology. Some clients experience problems because their cognitive deficits do notlet them foresee delayed orlong-range negative consequences. Others have trouble with concentration, directed thinking, orrecall. These difficulties occurin severe anxiety, depression, and panic attacks. Cognitive deficits produce perceptual errors as IVCll as faulty interpretations. Further,inadequate cognitive processing may interfere with the client's use of coping abilities ortechniques and with interpersonal problem solving, as occurs in suicidal people.

Finally, REBT views patients' beliefs as philosophically incongruent with reality. Meichenbaum (1977) criticizes this perspective, stating that nonpatients have irrational beliefs as well but are able to cope with them. Cognitive therapy teaches patients to self-correctfaulty cognitive processing and to bolster assumptions that allow them to cope. Thus, REBT views the problem as philosophical; cognitive therapy views it as functional.

Cognitive therapy shares many similarities with some forms of behaviortherapy but is quite differentfrom others. Within behaviortherapy are numerous approaches that vary in their emphasis on cognitive processes. At one end ofthe behavioral spectrum is applied behavioral analysis, an approach thatignores "internal events," such as interpretations and inferences, as much as possible. As one moves in the other direction, cognitive mediating processes are given increasing attention until one arrives at a variety of cognitive-behavioral approaches. Atthis point,the distinction between the purely cognitive and the distinctly behavioral becomes unclear.

Cognitive therapy and behaviortherapy share some features: They are empirical, present centered, and problem oriented, and they require explicitidentification of

problems and the situations in WLich they occur, as well as ofthe consequences resulting from them.In contrastto radical behaviorism, cognitive therapy applies the same kind offunctional analysis to internal experiences@to thoughts, attitudes, and images. Cognitions,like behaviors, can be modified by active collaboration through behavioral experiments thatfoster nCWAlearning. Also,in contrastto behavioral approaches based on simple conditioning paradigms, cognitive therapy sees individuals as active participants in their environments,judging and evaluating stimuli,interpreting events and sensations, and judging their own responses.

Studies of some behavioraltechniques, such as exposure methods forthe treatment of phobias, demonstrate that cognitive and behavioral changes work together. For example,in agoraphobia, cognitive improvement has been concomitant with behavioral improvement(Williams & Rappoport,1983). Simple exposure to agoraphobic situations while verbalizing negative automatic thoughts may lead to improvement on cognitive measures (Gournay,1986). Bandura (1977) has demonstrated that one ofthe most effective ways to change cognitions is to change performance.In real-life exposure, patients confront not only the threatening situations but also their personal expectatio of danger and their assumed inability to cope with theirreactions. Because the experienc itselfis processed cognitively, exposure can be considered a cognitive procedure.

Cognitive therapy maintains that a comprehensive approach to the treatment of anxiety and other disorders includes targeting anxiety-provoking thoughts and images. Work with depressed patients (Beck, Rush, Shaw, & Emery,1979) demonstrates that desired cognitive changes do not necessarily follow from changes in behavior. Forthis reason,itis vitalto know the patient's expectations,interpretations, and reactions to events. Cognitive change must be demonstrated, not assumed.

HISTORY

Precursors

Cognitive therapy's theoretical underpinnings are derived from three main sources: (1)the phenomenological approach to psychology,(2) structuraltheory and depth psychology, and (3) cognitive psychology. The phenomenological approach posits thatthe individual's view of self and the personal world are centralto behavior. This concept originated in Greek Stoic philosophy and can be seen in Immanuel Kant's (1798) emphasis on conscious subjective experience. This approach is also evidentin the writings of Adier(1936), Alexander(1950), Homey (1950), and Sullivan (1953).

The second majorinfluence was the structuraltheory and depth psychology of Kant and Freud, particularly Freud's concept ofthe hierarchical structuring of cognition into primary and secondary processes.

More recent developments in cognitive psychology also have had an impact. George Kelly (1955)is credited with being the first among contemporaries to describe the cognitive modelthrough his use of "personal constructs" and his emphasis on the role of beliefs in behavior change. Cognitive theories of emotion, such as those of Magda Arnold (1960) and Richard Lazarus (1984), WLich give primacy to cognition in emotional and behavioral change, have also contributed to cognitive therapy.

Beginnings

Cognitive therapy began in the early 1960s as the result of Aaron Beck's research on depression (Beck,1963,1964,1967). Trained in psychoanalysis, Beck attempted to validate Freud's theory of depression as having atits core "angerturned on the self."

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To substantiate this formulation, Beck made clinical observations of depressed patients and investigated theirtreatment undertraditional psychoanalysis. Ratherthan finding retroflected angerin theirthoughts and dreams, Beck observed a negative bias in their cognitive processing. With continued clinical observations and experimentaltesting, Beck developed his theory of emotional disorders and a cognitive model of depression.

The work of Albert Ellis (1962) gave majorimpetus to the development of cognitive behaviortherapies. Both Ellis and Beck believed that people can consciously adopt reason, and both viewed the patient's underlying assumptions as targets ofintervention. Similarly,they both rejected their analytic training and replaced passive listening with active, direct dialogues with patients. Whereas Ellis confronted patients and persuaded them that thephilosophies they lived by were unrealistic, Beck "turned the clientinto a colleague who researches verifiable reality" (Wessler,1986. p. 5).

The work of a number of contemporary behaviorists influenced the development of cognitive therapy. Bandura's (1977) concepts of expectancy ofreinforcement, self and outcome efficacies,the interaction between person and environment, modeling, and vicarious learning catalyzed a shiftin behaviortherapy toward the cognitive domain. Mahoney's (1974) early work on the cognitive control of behavior and his latertheoretical contributions also influenced cognitive therapy. Along with cognitive therapy and rational emotive behaviortherapy, Meichenbaum's (1977) cognitive-behavior modification is recognized as one ofthe three major self-controltherapies (Mahoney & Arnkoff, 1978). Meichenbaum's combination of cognitive modification and skills training in a coping skills paradigm is particularly usefulin treating anxiety, anger, and stress. The constructivist movementin psychology and the modern movementfor psychotherapy integration have been recentinfluences shaping contemporary cognitive therapy.

Current Status

integration have Model and Outcome Studies

Research has tested both the theoretical aspects ofthe cognitive model and the efficacy of cognitive therapy for a range of clinical disorders.In terms ofthe cognitive model of depression, negatively biased interpretations have been found in allforms of depression: unipolar and bipolar,reactive and endogenous (Haaga, Dyck, & Ernst,1991). The cognitive triad, negatively biased cognitive processing of stimuli, and identifiable dysfunctional beliefs have also been found to operate in depression (Hollon, Kendall, & Lumry, 1986). The efficacy of cognitive therapy for depression has been demonstrated in numerous studies summarized by Clark, Beck and Alford (1999). Recently, Beck (2008) has traced the evolution ofthe cognitive model of depression from its basis in information processing to its incorporation ofthe effect of early traumatic experiences on the formation of dysfunctional beliefs and sensitivity to precipitating factors in depression. He is presently interested in how genetic, neurochemical, and cognitive factors interact in depression.

Forthe anxiety disorders, a danger-related bias has been demonstrated in all anxiety diagnoses,including the presumed danger of physical sensations in panic attacks,the distorted perception of evaluation in social anxiety, and the negative appraisals of self and the world in PTSD. Moreover,the cognitive specificity hypothesis, which states that there is a distinct cognitive profile for each psychiatric disorder, has been supported for a range of disorders (Beck, 2005).

Controlled studies have demonstrated the efficacy of cognitive therapy in the treatment of panic disorder(Beck, Sokol, Clark, Berchick, & Wright,1992; Clark,1996; Clark, Salkovskis, Hackmann, Middleton, & Gelder,1992), social phobia (Clark,1997; Eng, Roth, & Heimberg, 2001), generalized anxiety disorder(Butler, Fennell, Robson,

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& Gelder,1991), substance abuse (Woody et al.,1983), eating disorders (Bowers, 2001; Fairburn, Jones, Peveler, Hope, Carr, Solomon, et al.,1991; Garner et al.,1993; Pike, Walsh, Vitousek, W士lson, & Bauer, 2003; Vitousek,1996), marital problems (Baucom, Sayers, & Sher,1990), obsessive-compulsive disorder(Freeston et al.,1997), post-traumatic stress disorder(Ehlers & Clark, 2000; Gillespie, Duffy, Hackmann, & Clark, 2002; Resick, 2001), and schizophrenia (Turkington, Dudley, Warman, & Beck, 2004; Zimmerman, Favrod, Trieu, & Pomini, 2005).

In addition, cognitive therapy appears to lead to lowerrates ofrelapse than other treatments for anxiety and depression (Clark,1996; Eng, Roth, & Heimberg, 2001; Hollon, DeRubeis, & Evans,1996; Hollon et al., 2005; Hollon, Stewart, & Strunk, 2006; Strunk & DeRubeis, 2001).

Suicide Research

Beck has developed key theoretical concepts regarding suicide and its prevention. Chief among his findings about suicide risk is the notion of hopelessness. Longitudinal studies of both inpatients and outpatients IVト○ had suicidalideation have found that a cutoff score of 9 or more on the Beck Hopelessness Scale is predictive of eventual suicide (Beck, Brown, Berchick, Stewart, & Steer,1990; Beck, Steer, Kovacs, & Garrison, 1985). Hopelessness has been confirmed as a predictor of eventual suicide in subsequent studies.

A recentrandomized controlled trialinvestigated the efficacy of a brief cognitive therapy treatmentforthose at high risk of attempting suicide by virtue ofthe factthat they had previously attempted suicide and had significant psychopathology and substance abuse problems. Results indicate that cognitive therapy reduced the rate of re-attempt by 50% over an 18-month period (Brown et al., 2005).

Psychotherapy Integration

Cognitive therapy has been integrated with other modalities to yield new therapeutic approaches. Schema therapy, developed by Jeffrey YOung (Young, Klosko, & Weishaar, 2003),focuses on modifying maladaptive core beliefs that are developed early in life and that can underlie chronic depression and anxiety. Another approach, mindfulness-based cognitive therapy (Segal, W工lliams, & Teasdale, 2002), uses acceptance and meditation strategies to promote resilience and preventrecurrence of depressive episodes.

Assessment Scales

Beck's work has generated a number of assessment scales, most notably the Beck Depression Inventory (Beck, Steer, & Brown,1996; Beck, Ward, Mendelson, Mock, & Erbaugh,1961),the Scale for Suicide Ideation (Beck, Kovacs, & Weissman,1979),the Suicide Intent Scale (Beck, Schuyler, & Herman,1974),the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler,1974),the Beck Anxiety Inventory (Beck & Steer, 1990),the Beck Self-concept Test(Beck, Steer, Brown, & Epstein,1990),the Dysfunctional Attitude Scale (Weissman & Beck,1978),the Sociotropy-Autonomy Scale (Beck, Epstein, & Harrison,1983),the Beck YOuth Inventories (Beck & Beck, 2002),the Personality Beliefs Questionnaire (Beck & Beck,1995), and the Clark-Beck Obsessive-Compulsive Inventory (Clark & Beck, 2002). The Beck Depression Inventory is the best known ofthese.It has been used in hundreds of outcome studies and is routinely employed by psychologists, physicians, and social WOrkers to monitor depression in their patients and clients.

The Centerfor Cognitive Therapy, Which is affiliated with the University of Pennsylvania Medical School, provides outpatient services and is a research institute thatintegrates clinical observations with empiricalfindings to develop theory. The Beck Institute in Bala Cynwyd, Pennsylvania, provides both outpatient services and training opportunities.In addition, clinical psychology internships and postdoctoralfellowships offertraining in cognitive therapy. RCsearch and treatment efforts in cognitive therapy are being conducted in a number of universities and hospitals in the United States and Europe. The International Cognitive Therapy Newsletter Was launched in 1985 forthe exchange ofinformation among cognitive therapists. Therapists from five continents participate in the newsletter network. Founded in 1971.the European Association for Behavioural and Cognitive Therapies will hold its annual conference in Milan in 2010. The World Congress of Behavioural and Cognitive Therapies, composed of seven organizations from around the world, will hold its next conference in 2010. The International Association for Cognitive Psychotherapy will hostthe 7th International Congress of Cognitive Psychotherapy in Istanbulin 2011.

The Academy of Cognitive Therapy, a nonprofit organization, Was founded in 1999 by a group ofleading clinicians, educators, and researchers in the field of cognitive therapy. The academy administers an objective evaluation to identify and certify clinicians skilled in cognitive therapy.In 1999.the Accreditation Councilfor Graduate Medical Education mandated that psychiatry residency training programs train residents to be competentin the practice of cognitive behaviortherapy.

Cognitive therapists routinely contribute to psychology, psychiatry, and behavior therapy journals. The primary journals devoted to research in cognitive therapy are Cognitive Therapy and Research,the Journal of Cognitive Psychotherapy: An International Quarterly, and Cognitive and Behavioral Practice.

Cognitive therapy is represented atthe annual meetings ofthe American Psychological Association,the American Psychiatric Association,the American Association of Suicidology, and others.It has been such a majorforce in the Association forthe Advancement of Behavior Therapy thatthe organization changed its name in 2005 to the Association for Behavioral and Cognitive Therapies (ABCT).

Because ofits efficacy as a short-term form of psychotherapy, cognitive therapy is achieving wider use in settings that must demonstrate cost-effectiveness orthatrequire short-term contact with patients.It has applications in both inpatient and outpatient settings.

Many talented researchers and innovative therapists have contributed to the development of cognitive therapy. Controlled outcome studies comparing cognitive therapy with otherforms oftreatment are conducted with anxiety disorders, panic, drug abuse, anorexia and bulimia, geriatric depression, acute depression, and dysphoric disorder. Beck's students and associates do research on the nature and treatment of depression, anxiety,loneliness, marital conflict, eating disorders, agoraphobia, pain, personality disorders, substance abuse, bipolar disorder, and schizophrenia.

PERSONALITY

Theory of Personality

Cognitive therapy emphasizes the role ofinformation processing in human responses and adaptation. When an individual perceives thatthe situation requires a response, a whole set of cognitive, emotional, motivational, and behavioral schemas are mobilized. Previously, cognitive therapy viewed cognition as largely determining emotions

and behaviors. Currentthinking views all aspects of human functioning as acting simultaneously as a mode.

Cognitive therapy views personality as shaped by the interaction between innate disposition and environment(Beck, Freeman, & Davis, 2003). Personality attributes are seen as reflecting basic schemas, orinterpersonal "strategies," developed in response to the environment.

Cognitive therapy sees psychological distress as being the consequence of a numbe offactors. Although people may have biochemical predispositions to illness,they respond to specific stressors because oftheirlearning history. The phenomena of psychopathology (but not necessarily the cause) are on the same continuum as normal emotionalreactions, butthey are manifested in exaggerated and persistent ways.In depression,for example, sadness and loss ofinterest are intensified and prolonged,in mania there is heightened investmentin self-aggrandizement, and in anxiety there is an extreme sense of vulnerability and danger.

Individuals experience psychological distress when they perceive a situation as threatening their vitalinterests. At such times,their perceptions and interpretations of events are highly selective, egocentric, and rigid. This results in a functionalimpairme of normal cognitive activity. There is a decreased ability to turn offidiosyncratic thin ing,to concentrate,recall, orreason. Corrective functions, WHich allow reality testing and refinement of global conceptualizations, are attenuated.

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Each individual has a set ofidiosyncratic vulnerabilities and sensitivities that predispose him or herto psychological distress. These vulnerabilities appearto be related to personality structure. Personality is shaped by temperament and cognitive schemas. Cognitive schemas are structures that contain the individual's fundamental beliefs and assumptions. Schemas develop early in life from personal experience and identification with significant others. These concepts are reinforced by furtherlearning experiences and,in turn,influence the formation of beliefs, values, and attitudes.

Cognitive schemas may be adaptive or dysfunctional. They may be general or specific in nature. A person may have competing schemas. Cognitive schemas are generally latent but become active WHen stimulated by specific stressors, circumstances, or stimuli.In personality disorders,they are triggered very easily and often so thatthe person overresponds to a wide range of situations in a stereotyped manner.

Cognitive schem

cific in nature. A per

The idea that certain clusters of personality attributes or cognitive structures are related to certain types of emotionalresponse has been studied by Beck, Epstein, and Harrison (1983), IVHo found two major personality dimensions relevantto depression and possibly to other disorders: social dependence (sociotropy) and autonomy. Beck's research revealed that dependentindividuals became depressed following disruption ofrelationships. Autonomous people became depressed after defeat orfailure to attain a desired goal. The sociotropic dimension is organized around closeness, nurturance, and dependence,the autonomous dimension around independence, goal setting, self-determination, and self-imposed obligations.

Research has also established that although "pure" cases of sociotropy and autonomy do exist, most people display features of each, depending on the situation. Thus, sociotropy and autonomy are styles of behavior, notfixed personality structures. This position stands in marked contrast with psychodynamic theories of personality, WIIich postulate fixed personality dimensions.

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Thus, cognitive therapy views personality as reflecting the individual's cognitive organization and structure, WIIich are both biologically and socially influenced. VI I thin the constraints of one's neuroanatomy and biochemistry, personallearning experiences help determine hOW one develops and responds.

Variety

Cognitive therapy emphasizes the individual's learning history,including the influence of significantlife events,in the development of psychological disturbance.Itis not a reductive model butrecognizes that psychological distress is usually the result of many interacting factors.

Cognitive therapy's emphasis on the individual's learning history endorses social learning theory and the importance ofreinforcement. The sociallearning perspective requires a thorough examination ofthe individual's developmental history and his or her own idiosyncratic meanings and interpretations of events. Cognitive therapy emphasizes the idiographic nature of cognition, because the same event may have very different meanings fortwo individuals.

The conceptualization of personality as reflective of schemas and underlying assumptions is also related to sociallearning theory. The way a person structures experience is based on consequences of past behavior, vicarious learning from significant others, and expectations aboutthe future.

T rience is based

Psychological distress is ultimately caused by many innate, biological, developmental, and environmentalfactors interacting with one another, so there is no single "cause" of psychopathology. Depression,forinstance,is characterized by predisposing factors such as hereditary susceptibility, diseases that cause persistent neurochemical abnormalities, developmentaltraumas leading to specific cognitive vulnerabilities, inadequate personal experiences thatfailto provide appropriate coping skills, and counterproductive cognitive patterns, such as unrealistic goals, assumptions, or imperatives. Physical disease, severe and acute stress, and chronic stress are also precipitating factors.

inadequate pers

Systematic errors in reasoning called cognitive distortions are evident during psychological distress (Beck,1967).

Arbitrary inference: Drawing a specific conclusion without supporting evidence or even in the face of contradictory evidence. An example is the WOrking mother WIIo concludes, after a particularly busy day, "I'm a terrible mother."

Selective abstraction: Conceptualizing a situation on the basis of a detailtaken out of context,ignoring otherinformation. An example is the man WIIo becomes jealous upon seeing his girlfriend tilt her head toward another man to hear him better at a noisy party.

Overgeneralization: A ⊦stracting a generalrule from one or a few isolated incidents and applying ittoo broadly and to unrelated situations. After a discouraging date, a woman concluded, "All men are alike.I'll always be rejected."

Magnification and minimization: Seeing something as far more significant orless significantthan it actually is. A student catastrophized, "IfI appearthe least bit nervous

in class,it will mean disaster." Another person,ratherthan facing the factthat his motheris terminally ill, decides that she will soon recoverfrom her "cold."

Personalization: Attributing external events to oneself without evidence supporting a causal connection. A man waved to an acquaintance across a busy street. After not getting a greeting in return, he concluded, "I must have done something to offend him."

Dichotomous thinking: Categorizing experiences in one oftwo extremes;for example, as complete success ortotalfailure. A doctoral candidate stated, "Unless I write the best exam they've ever seen,I'm a failure as a student."

Systematic Bias in Psychological Disorders

A bias in information processing characterizes most psychological disorders (see Table 8.1). This bias is generally applied to "external" information, such as communications orthreats, and may start operating at early stages ofinformation processing. A person's orienting schema identifies a situation as posing a danger orloss,for instance, and signals the appropriate mode to respond.

ıuıg· Model of Depression

A cognitive triad characterizes depression (Beck,1967). The depressed individual has a negative view ofthe self,the world, and the future and perceives the self as inadequate, deserted, and worthless. A negative view is apparentin beliefs that enormous demands exist and thatimmense barriers block access to goals. The world seems devoid of pleasure or gratification. The depressed person's view ofthe future is pessimistic,reflecting the beliefthat currenttroubles will notimprove. This hopelessness may lead to suicidalideation.

Motivational, behavioral, emotional, and physical symptoms of depression are also activated in the depressed mode. These symptoms influence a person's beliefs and assumptions, and vice versa. For example, motivational symptoms of paralysis of will are related to the beliefthat one lacks the ability to cope orto control an event's outcome.

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sumptions, and vice versa. For example, motivational symptoms of
related to the belief that one lacks the ability to cope or to control a

TABLE 8.1 The Cognitive Profile of Psychological Disorders

Disorder	Systematic Bias in Processing Informat
Depression	Negative view of self, experience, and fu
Hypomania	Inflated view of self and future
Anxiety disorder	Sense of physical or psychological dang
Panic disorder	Catastrophic interpretation of bodily/m
Phobia	Sense of danger in specific, avoidable sit

Consequently, there is a reluctance to commit oneself to a goal. Suicidal wishes often reflect a desire to escape unbearable problems.

The increased dependency often observed in depressed patients reflects the view of self as incompetent, an overestimation of the difficulty of normal life tasks, the expectation of failure, and the desire for someone more capable to take over. Indecisiveness similarly reflects the belief that one is incapable of making correct decisions. The physical symptoms of depression—low energy, fatigue, and inertia—are also related to negative expectations. Work with depressed patients indicates that initiating activity actually reduces inertia and fatigue. Moreover, refuting negative expectations and demonstrating motor ability play important roles in recovery.

motor ability play important roles

Anxiety disorders are conceptualized as excessive functioning or malfunctioning of normal survival mechanisms. Thus, the basic mechanisms for coping with threat are the same for both normal and anxious people: physiological responses prepare the body for escape or self-defense. The same physiological responses occur in the face of psychosocial threats as in the case of physical dangers. The anxious person's perception of danger is either based on false assumptions or exaggerated, whereas the normal response is based on a more accurate assessment of risk and the magnitude of danger. In addition, normal individuals can correct their misperceptions using logic and evidence. Anxious individuals have difficulty recognizing cues of safety and other evidence that would reduce the threat of danger. Thus, in cases of anxiety, cognitive content revolves around themes of danger, and the individual tends to maximize the likelihood of harm and minimize his or her ability to cope.

Mania

The manic patient's biased thinking is the reverse of the depressive's. Such individuals selectively perceive significant gains in each life experience, blocking out negative experiences or reinterpreting them as positive, and unrealistically expecting favorable results from various enterprises. Exaggerated concepts of abilities, worth, and accomplishments lead to feelings of euphoria. The continued stimulation from inflated self-evaluations and overly optimistic expectations provides vast sources of energy and drives the manic individual into continuous goal-directed activity.

Panic Disorder

Patients with panic disorder are prone to regard any unexplained symptom or sensation as a sign of some impending catastrophe. Their cognitive processing system focuses their attention on bodily or psychological experiences and shapes these sources of internal information into the conviction that disaster is imminent. Each patient has a specific "equation." For one, distress in the chest or stomach equals heart attack; for another, shortness of breath means the cessation of all breathing; and for another, lightheadedness is a sign of impending unconsciousness.

Some patients regard a sudden surge of anger as a sign that they will lose control and injure somebody. Others interpret a mental lapse, momentary confusion, or mild disorientation to mean that they are losing their mind. A crucial characteristic of people having panic attacks is the conclusion that vital systems (the cardiovascular, respiratory, or central nervous system) will collapse. Because of their fear, they tend to be overly vigilant toward internal sensations and thus to detect and magnify sensations that pass unnoticed in other people.

Patients with panic disorder shOW a specific cognitive deficit in their symptoms and catastrophic interpretations realistically

Agoraphobia

Patients WHo have had one or more panic attacks in a particular situation tend to avoid that situation. For example, people WLo have had panic attacks in supermarkets avoid going there.Ifthey push themselves to go,they become increasingly vigilanttoward their sensations and begin to anticipate having another panic attack.

The anticipation of such an attack triggers a variety of autonomic symptoms that are then misinterpreted as signs of an impending disaster(e.g., heart attack,loss of consciousness, suffocation), WHich can lead to a full-blown panic attack. Patients with a panic disorderthat goes untreated frequently develop agoraphobia. They may eventually become housebound or so restricted in their activities thatthey cannottravelfar from home and require a companion to venture any distance.

Phobia

In phobias,there is anticipation of physical or psychological haて伽 in specific situations. As long as patients can avoid these situations,they do notfeelthreatened and may be relatively comfortable. When they enterinto these situations, however,they experience the typical subjective and physiological symptoms of severe anxiety. As a result ofthis unpleasantreaction,theirtendency to avoid the situation in the future is reinforced.

In evaluation phobias,there is fear of disparagement orfailure in social situations, examinations, and public speaking. The behavioral and physiologicalreactions to the potential "danger" (rejection, devaluation,failure) may interfere with the patient's functioning to the extentthatthey can produce just WトatIhe patientfears will happen.

Paranoid States

The paranoid individualis biased toward attributing prejudice to others. The paranoid persists in assuming that other people are deliberately abusive,interfering, or critical.In contrastto depressed patients, WトO believe that supposed insults orrejections are justified, paranoid patients persevere in thinking that others treatthem unjustly.

Unlike depressed patients, paranoid patients do not experience low self-esteem. They are more concerned with the injustice ofthe presumed attacks,thwarting, or intrusions than with the actualloss, and they rail againstthe presumed prejudice and malicious intent of others.

Obsessions and Compulsions

Patients with obsessions introduce uncertainty into the appraisal of situations that most people would consider safe. The uncertainty is generally attached to circumstances that are potentially unsafe and is manifested by continual doubts@even though there is no evidence of danger.

Obsessives continually doubt WLetherthey have performed an act necessary for safety (for example,turning off a gas oven orlocking the door at night). They may fear contamination by germs, and no amount ofreassurance can alleviate the fear. A key characteristic of obsessives is this sense ofresponsibility and the beliefthatthey

are accountable for having taken an action@or having failed to take an action@that could harm them or others. Cognitive therapy views such intrusive thoughts as universal.Itis the meaning assigned to the intrusive thought@thatthe patient has done something immoral or dangerous@that causes distress.

Compulsions are attempts to reduce excessive doubts by performing rituals designed to neutralize the anticipated disaster. A hand-washing compulsion,forinstance, is based on the patients' beliefthatthey have notremoved allthe dirt or contaminants from parts oftheir body. Some patients regard dirt as a source of danger, either as a cause of physical disease or as a source of offensive, unpleasant odors, and they are compelled to remove this source of physical or social danger.

Suicidal Behavior

The cognitive processing in suicidalindividuals has two features. First,there is a high degree of hopelessness or beliefthatthings cannotimprove. A second feature is a cognitive deficit@a difficulty in solving problems. Although the hopelessness accentuates poor problem solving, and vice versa,the difficulties in coping with life situations can, by themselves, contribute to the suicidal potential. Thinking becomes more rigid, and suicide appears as the only alternative in a diminished response repertoire.

Anorexia Nervosa

Anorexia nervosa and bulimia represent a constellation of maladaptive beliefs thatrevolve around one central assumption: "My body IVCight and shape determine my WOrth and/or my social acceptability." Revolving around this assumption are such beliefs as "I will look ugly ifI gain much more WCight," "The only thing in my life thatI can controlis my weight," and "IfI don't starvemyself,I willlet go completely and become enormous."

Anorexics show typical distortions in information processing. They misinterpret symptoms offullness after meals as signs thatthey are getting fat. And they misperceive theirimage in a mirror or photograph as being much fatterthan it actually is.

Schizophrenia

In schizophrenia,there is a complex interaction of predisposing neurobiological, environmental, cognitive, and behavioralfactors. The impaired integrative function ofthe brain, along with specific cognitive deficits,increases vulnerability to stressfullife events and leads to dysfunctional beliefs (e.g., "I am inferior.") and behaviors (e.g., social withdrawal). Excessive psychophysiologicalreactions occurin response to stress and repeated negative thinking. The release of corticosteroids activates the dopaminergic system, WHich contributes to the development of delusions and hallucinations. Cognitive disorganization is a result of neurocognitive deficits such as attentional problems, impaired executive function and working memory. These impairments interact with heightened rejection sensitivity to produce communication deviance and intrusive,inappropriate thoughts. Delusions stem from the interplay of cognitive biases like external attributions and the cognitive shortcut ofjumping to conclusions. A tendency to perceptualize combines with negative self-schemas to generate auditory hallucinations, which are exacerbated by beliefs thatthe "voice" is uncontrollable, powerful,infallible, and externally generated. Engagementin social, vocational, and pleasurable activity is compromised by neurocognitive impairmentthatis magnified by dysfunctional attitudes such as socialindifference,low expectancies for pleasure, and defeatist beliefs regarding task performance. LOV expectations for performance and success further contribute to negative symptoms.

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