PSYCHOTHERAPY

Theory of Psychotherapy

The goals of cognitive therapy are to correct faulty information processing and to help patients modify assumptions that maintain maladaptive behaviors and emotions. Cognitive and behavioral methods are used to challenge dysfunctional beliefs and to promote more realistic adaptive thinking. Cognitive therapy initially addresses symptom relief, but its ultimate goals are to remove systematic biases in thinking and modify the core beliefs that predispose the person to future distress.

Cognitive therapy fosters change in patients' beliefs by treating beliefs as testable hypotheses to be examined through behavioral experiments jointly agreed upon by patient and therapist. The cognitive therapist does not tell the client that the beliefs are irrational or wrong or that the beliefs of the therapist should be adopted. Instead, the therapist asks questions to elicit the meaning, function, usefulness, and consequences of the patient's beliefs. The patient ultimately decides whether to reject, modify, or maintain all personal beliefs, being well aware of their emotional and behavioral consequences.

Cognitive therapy is not the substitution of positive beliefs for negative ones. It is based in reality, not in wishful thinking. Similarly, cognitive therapy does not maintain that people's problems are imaginary. Patients may have serious social, financial, or health problems as well as functional deficits. In addition to real problems, however, they have biased views of themselves, their situations, and their resources that limit their range of responses and prevent them from generating solutions.

Cognitive change can promote behavioral change by allowing the patient to take risks. In turn, experience in applying new behaviors can validate the new perspective. Emotions can be moderated by enlarging perspectives to include alternative interpretations of events. Emotions play a role in cognitive change, for learning is enhanced when emotions are triggered. Thus, the cognitive, behavioral, and emotional channels interact in therapeutic change, but cognitive therapy emphasizes the primacy of cognition in promoting and maintaining therapeutic change.

Cognitive change occurs at several levels: voluntary thoughts, continuous or automatic thoughts, underlying assumptions, and core beliefs. According to the cognitive model, cognitions are organized in a hierarchy, each level differing from the next in its accessibility and stability. The most accessible and least stable cognitions are voluntary thoughts. At the next level are automatic thoughts, which come to mind spontaneously when triggered by circumstances. They are the thoughts that intercede between an event or stimulus and the individual's emotional and behavioral reactions.

An example of an automatic thought is "Everyone will see I'm nervous," experienced by a socially anxious person before going to a party. Automatic thoughts are accompanied by emotions and at the time they are experienced seem plausible, are highly salient, and are internally consistent with individual logic. They are given credibility without ever being challenged. Although automatic thoughts are more stable and less accessible than voluntary thoughts, patients can be taught to recognize and monitor them. Cognitive distortions are evident in automatic thoughts.

Automatic thoughts are generated from underlying assumptions. For example, the belief "I am responsible for other people's happiness" produces numerous negative automatic thoughts in people who perceive themselves as causing distress to others. Assumptions shape perceptions into cognitions, determine goals, and provide interpretations and meanings to events. They may be quite stable and outside the patient's awareness.

Core beliefs are contained in cognitive schemas. Therapy aims at identifying these absolute beliefs and counteracting their effects. If the beliefs themselves can be changed, the patient is less vulnerable to future distress. In Schema therapy, these core beliefs are called Early Maladaptive Schemas (EMSs; Young, Klosko, & Weishaar. 2003).

The Therapeutic Relationship

The therapeutic relationship is collaborative. The therapist assesses sources of distress and dysfunction and helps the patient clarify goals. In cases of severe depression or anxiety, patients may need the therapist to take a directive role. In other instances, patients may take the lead in determining goals for therapy. As part of the collaboration, the patient provides the thoughts, images, and beliefs that occur in various situations, as well as the emotions and behaviors that accompany the thoughts. The patient also shares responsibility by helping to set the agenda for each session and by doing homework between sessions. Homework helps therapy to proceed more quickly and gives the patient an opportunity to practice newly learned skills and perspectives.

The therapist functions as a guide who helps the patient understand how beliefs and attitudes interact with affect and behavior. The therapist is also a catalyst who promotes corrective experiences that lead to cognitive change and skills acquisition. Thus, cognitive therapy employs a learning model of psychotherapy. The therapist has expertise in examining and modifying beliefs and behavior but does not adopt the role of a passive expert.

Cognitive therapists actively pursue the patient's point of view. By using warmth, accurate empathy, and genuineness (see Rogers, 1951), the cognitive therapist appreciates the patient's personal world view. However, these qualities alone are not sufficient for therapeutic change. The cognitive therapist specifies problems, focuses on important areas, and teaches specific cognitive and behavioral techniques.

Along with having good interpersonal skills, cognitive therapists are flexible. They are sensitive to the patient's level of comfort and use self-disclosure judiciously. They provide supportive contact, when necessary, and operate within the goals and agenda of the cognitive approach. Flexibility in the use of therapeutic techniques depends on the targeted symptoms. For example, the inertia of depression responds best to behavioral interventions, whereas the suicidal ideation and pessimism of depression respond best to cognitive techniques. A good cognitive therapist does not use techniques arbitrarily or mechanically but applies them with sound rationale and skill—and with an understanding of each individual's needs.

To maintain collaboration, the therapist elicits feedback from the patient, usually at the end of each session. Feedback focuses on what the patient found helpful or not helpful, whether the patient has concerns about the therapist, and whether the patient has questions. The therapist may summarize the session or ask the patient to do so. Another way the therapist encourages collaboration is by providing the patient with a rationale for each procedure used. This demystifies the therapy process, increases patients' participation, and reinforces a learning paradigm in which patients gradually assume more responsibility for therapeutic change.

Definitions

Three fundamental concepts in cognitive therapy are collaborative empiricism, Socratic dialogue, and guided discovery.

Collaborative Empiricism. The therapeutic relationship is collaborative and requires jointly determining the goals for treatment, eliciting and providing feedback, and thereby demystifying how therapeutic change occurs. The therapist and patient become co-investigators, examining the evidence to support or reject the patient's cognitions. As in scientific inquiry, interpretations or assumptions are treated as testable hypotheses.

Empirical evidence is used to determine whether particular cognitions serve any useful purpose. Prior conclusions are subjected to logical analysis. Biased thinking

is exposed as the patient becomes aware of alternative sources of information. This process is conducted as a partnership between patient and therapist, with either taking a more active role as needed.

Socratic Dialogue. Questioning is a major therapeutic device in cognitive therapy, and Socratic dialogue is the preferred method. The therapist carefully designs a series of questions to promote new learning. The purposes of the therapist's questions are generally to (1) clarify or define problems, (2) assist in the identification of thoughts, images, and assumptions, (3) examine the meanings of events for the patient, and (4) assess the consequences of maintaining maladaptive thoughts and behaviors.

Socratic dialogue implies that the patient arrives at logical conclusions based on the questions posed by the therapist. Questions are not used to "trap" patients, lead them to inevitable conclusions, or attack them. Questions enable the therapist to understand the patient's point of view and are posed with sensitivity so that patients may look at their assumptions objectively and nondefensively.

Young, Rygh, Weinberger, and Beck (2008, p. 274) describe how questions change throughout the course of therapy:

> In the beginning of therapy, questions are employed to obtain a full and detailed picture of the patient's particular difficulties. They are used to obtain background and diagnostic data; to evaluate the patient's stress tolerance, capacity for introspection, coping methods and so on; to obtain information about the patient's external situation and interpersonal context; and to modify vague complaints by working with the patient to arrive at specific target problems to work on.
>
> As therapy progresses, the therapist uses questioning to explore approaches to problems, to help the patient weigh advantages and disadvantages of possible solutions, to examine the consequences of staying with particular maladaptive behaviors, to elicit automatic thoughts, and to demonstrate EMSs and their consequences. In short, the therapist uses questioning in most cognitive therapeutic techniques.

Guided Discovery. Through guided discovery, the patient modifies maladaptive beliefs and assumptions. The therapist serves as a guide who elucidates problem behaviors and errors in logic by designing new experiences (*behavioral experiments*) that lead to the acquisition of new skills and perspectives. Guided discovery implies that the therapist does not exhort or cajole the patient to adopt a new set of beliefs. Rather, the therapist encourages the patient's use of information, facts, and probabilities to obtain a realistic perspective.

Process of Psychotherapy

Initial Sessions

The goals of the first interview are to initiate a relationship with the patient, to elicit essential information, and to produce symptom relief. Building a relationship with the patient may begin with questions about feelings and thoughts about beginning therapy. Discussing the patient's expectations helps put the patient at ease, yields information about the patient's expectations, and presents an opportunity to demonstrate the relationship between cognition and affect (Beck, Rush, et al., 1979). The therapist also uses the initial sessions to accustom the patient to cognitive therapy, establish a collaborative framework, and deal with any misconceptions about therapy. The types of information the therapist seeks in the initial session include diagnosis, past history, present life situation, psychological problems, attitudes about treatment, and motivation for treatment.

Problem definition and symptom relief begin in the first session. Although problem definition and collection of background information may take several sessions, it is often critical to focus on a very specific problem and provide rapid relief in the first session. For example, a suicidal patient needs direct intervention to undermine hopelessness immediately. Symptom relief can come from several sources: specific problem solving, clarifying vague or general complaints into workable goals, or gaining objectivity about a disorder (e.g., making it clear that a patient's symptoms represent anxiety and nothing worse, or that difficulty concentrating is a symptom of depression and not a sign of brain disease).

Problem definition entails both functional and cognitive analyses of the problem. A functional analysis identifies elements of the problem: how it is manifested; situations in which it occurs; its frequency, intensity, and duration; and its consequences. A cognitive analysis of the problem identifies the thoughts and images a person has when emotion is triggered. It also includes investigation of the extent to which the person feels in control of thoughts and images, what the person imagines will happen in a distressing situation, and the probability of such an outcome actually occurring.

In the early sessions, then, the cognitive therapist plays a more active role than the patient. The therapist gathers information, conceptualizes the patient's problems, socializes the patient to cognitive therapy, and actively intervenes to provide symptom relief. The patient is assigned homework beginning at the first session.

Homework, at this early stage, is usually directed at recognizing the connections among thoughts, feelings, and behavior. For example, patients might be asked to record their automatic thoughts when distressed. Thus, the patient is trained from the outset to self-monitor thoughts and behaviors. In later sessions, the patient plays an increasingly active role in determining homework, and assignments focus on testing very specific assumptions.

During the initial sessions, a problem list is generated. The problem list may include specific symptoms, behaviors, or pervasive problems. These problems are assigned priorities as targets for intervention. Priorities are based on the relative magnitude of distress, the likelihood of making progress, the severity of symptoms, and the pervasiveness of a particular theme or topic.

If the therapist can help the patient solve a problem early in treatment, this success can motivate the patient to make further changes. As each problem is approached, the therapist chooses the appropriate cognitive or behavioral technique to apply and provides the patient with a rationale for the technique. Throughout therapy, the therapist elicits the patient's reactions to various techniques to ascertain whether they are being applied correctly, whether they are successful, and how they can be incorporated into homework or practical experience outside the session.

Middle and Later Sessions

As cognitive therapy proceeds, the emphasis shifts from the patient's symptoms to the patient's patterns of thinking. The connections among thoughts, emotions, and behavior are chiefly demonstrated through the examination of automatic thoughts. Once the patient can challenge thoughts that interfere with functioning, he or she can consider the underlying assumptions that generate such thoughts.

There is usually a greater emphasis on cognitive than on behavioral techniques in later sessions, which focus on complex problems that involve several dysfunctional thoughts. Often these thoughts are more amenable to logical analysis than to behavioral experimentation. For example, the prophecy "I'll never get what I want in life" is not easily tested. However, one can question the logic of this generalization and look at the advantages and disadvantages of maintaining it as a belief.

Often such assumptions outside the patient's awareness are discovered as themes of automatic thoughts. When automatic thoughts are observed over time and across situations, assumptions appear or can be inferred. Once these assumptions and their power have been recognized, therapy aims at modifying them by examining their validity, adaptiveness, and utility for the patient.

In later sessions, the patient assumes more responsibility for identifying problems and solutions and for creating homework assignments. The therapist takes on the role of advisor rather than teacher as the patient becomes better able to use cognitive techniques to solve problems. The frequency of sessions decreases as the patient becomes more self-sufficient. Therapy is terminated when goals have been reached and the patient feels able to practice his or her new skills and perspectives independently.

Ending Treatment

Length of treatment depends primarily on the severity of the client's problems. The usual length for unipolar depression is 15 to 25 sessions at weekly intervals (Beck, Rush, et al., 1979). Moderately to severely depressed patients usually require sessions twice a week for 4 to 5 weeks and then weekly sessions for 10 to 15 weeks. Most cases of anxiety are treated within a comparable period of time.

Some patients find it extremely difficult to tolerate the anxiety involved in giving up old ways of thinking. For them, therapy may last several months. Still others experience early symptom relief and leave therapy early. In these cases, little structural change has occurred, and problems are likely to recur.

From the outset, the therapist and patient share the expectation that therapy is time limited. Because cognitive therapy is present centered and time limited, there tend to be fewer problems with termination than in longer forms of therapy. As the patient develops self-reliance, therapy sessions become less frequent.

Termination is planned for, even in the first session as the rationale for cognitive therapy is presented. Patients are told that a goal of the therapy is for them to learn to be their own therapists. The problem list makes explicit what is to be accomplished in treatment. Behavioral observation, self-monitoring, self-report, and sometimes questionnaires (e.g., the Beck Depression Inventory) measure progress toward the goals on the problem list. Feedback from the patient aids the therapist in designing experiences to foster cognitive change.

Some patients have concerns about relapse or about functioning autonomously. Some of these concerns include cognitive distortions, such as dichotomous thinking ("I'm either sick or 100% cured") or negative prediction ("I'll get depressed again and won't be able to help myself"). It may be necessary to review the goal of therapy: to teach the patient ways to handle problems more effectively, not to produce a "cure" or restructure core personality (Beck, Rush, et al., 1979). Education about psychological disorders, such as acknowledging the possibility of recurrent depression, is done throughout treatment so that the patient has a realistic perspective on prognosis.

During the usual course of therapy, the patient experiences both successes and setbacks. Such problems give the patient the opportunity to practice new skills. As termination approaches, the patient can be reminded that setbacks are normal and have been handled before. The therapist might ask the patient to describe how prior specific problems were handled during treatment. Therapists can also use cognitive rehearsal prior to termination by having patients imagine future difficulties and report how they would deal with them.

Termination is usually followed by one to two booster sessions, usually 1 month and 2 months after termination. Such sessions consolidate gains and assist the patient in employing new skills.

Mechanisms of Psychotherapy

Several common denominators cut across effective treatments. Three mechanisms of change common to all successful forms of psychotherapy are (1) a comprehensible framework, (2) the patient's emotional engagement in the problem situation, and (3) reality testing in that situation.

Cognitive therapy maintains that the modification of dysfunctional assumptions leads to effective cognitive, emotional, and behavioral change. Patients change by recognizing automatic thoughts, questioning the evidence used to support them, and modifying cognitions. Next, the patient behaves in ways congruent with new, more adaptive ways of thinking.

Change can occur only if the patient experiences a problematic situation as a real threat. According to cognitive therapy, core beliefs are linked to emotions, and with affective arousal, those beliefs become accessible and modifiable. One mechanism of change, then, focuses on making accessible those cognitive constellations that produced the maladaptive behavior or symptomatology. This mechanism is analogous to what psychoanalysts call "making the unconscious conscious."

Simply arousing emotions and the accompanying cognitions are not sufficient to cause lasting change. People express emotion, sometimes explosively, throughout their lives without benefit. However, the therapeutic milieu allows the patient to experience emotional arousal and reality testing simultaneously. For a variety of psychotherapies, what is therapeutic is the patient's ability to be engaged in a problem situation and yet respond to it adaptively. In terms of cognitive therapy, this means to experience the cognitions and to test them within the therapeutic framework.

APPLICATIONS

Who Can We Help?

Cognitive therapy is a present-centered, structured, active, cognitive, problem-oriented approach best suited for cases in which problems can be delineated and cognitive distortions are apparent. It was originally developed for the treatment of Axis I disorders but has been elaborated to treat Axis II disorders as well. It has wide-ranging applications to a variety of clinical and nonclinical problems. Though originally used in individual psychotherapy, it is now used with couples, families, and groups. It can be applied alone or in combination with pharmacotherapy in inpatient and outpatient settings.

Cognitive therapy is widely recognized as an effective treatment for unipolar depression. Beck, Rush, et al. (1979, p. 27) list criteria for using cognitive therapy alone or in combination with medication. It is the treatment of choice in cases where the patient refuses medication, prefers a psychological treatment, has unacceptable side effects to antidepressant medication, has a medical condition that precludes the use of antidepressants, or has proved to be refractory to adequate trials of antidepressants. Recent research by DeRubeis, Hollon, et al. (2005) indicates that cognitive therapy can be as effective as medications for the initial treatment of moderate to severe major depression.

Cognitive therapy is not recommended as the exclusive treatment in cases of bipolar affective disorder or psychotic depression. It is also not used alone for the treatment of other psychoses, such as schizophrenia. Some patients with anxiety may begin treatment on medication, but cognitive therapy teaches them to function without relying on medication.

Cognitive therapy produces the best results with patients who have adequate reality testing (i.e., no hallucinations or delusions), good concentration, and sufficient memory functions. It is ideally suited to patients who can focus on their automatic thoughts,

accept the therapist–patient roles, are willing to tolerate anxiety in order to do experiments, can alter assumptions permanently, take responsibility for their problems, and are willing to postpone gratification in order to complete therapy. Although these ideals are not always met, this therapy can proceed with some adjustment of outcome expectations and flexibility of structure. For example, therapy may not permanently alter schemas but may improve the patient's daily functioning.

Cognitive therapy is effective for patients with different levels of income, education, and background (Persons, Burns, & Perloff, 1988). As long as the patient can recognize the relationships among thoughts, feelings, and behaviors and takes some responsibility for self-help, cognitive therapy can be beneficial.

Treatment

Cognitive therapy consists of highly specific learning experiences designed to teach patients (1) to monitor their negative, automatic thoughts (cognitions), (2) to recognize the connections among cognition, affect, and behavior, (3) to examine the evidence for and against distorted automatic thoughts, (4) to substitute more reality-oriented interpretations for these biased cognitions, and (5) to learn to identify and alter the beliefs that predispose them to distort their experiences (Beck, Rush, et al., 1979).

Both cognitive and behavioral techniques are used in cognitive therapy to reach these goals. The technique used at any given time depends on the patient's level of functioning and on the particular symptoms and problems presented.

Cognitive Techniques

Verbal techniques are used to elicit the patient's automatic thoughts, analyze the logic behind the thoughts, identify maladaptive assumptions, and examine the validity of those assumptions. Automatic thoughts are elicited by questioning the patient about those thoughts that occur during upsetting situations. If the patient has difficulty recalling thoughts, imagery or role playing can be used. Automatic thoughts are most accurately reported when they occur in real-life situations. Such "hot" cognitions are accessible, powerful, and habitual. The patient is taught to recognize and identify thoughts and to record them when upset.

Cognitive therapists do not interpret patients' automatic thoughts but, rather, explore their meanings, particularly when a patient reports fairly neutral thoughts yet displays strong emotions. In such cases, the therapist asks what those thoughts mean to the patient. For example, after an initial visit, an anxious patient called his therapist in great distress. He had just read an article about drug treatments for anxiety. His automatic thought was "Drug therapy is helpful for anxiety." The meaning he ascribed to this was "Cognitive therapy can't possibly help me. I am doomed to failure again."

Automatic thoughts are tested by direct evidence or by logical analysis. Evidence can be derived from past and present circumstances, but, true to scientific inquiry, it must be as close to the facts as possible. Data can also be gathered in behavioral experiments. For example, if a man believes he cannot carry on a conversation, he might try to initiate brief exchanges with three people. The empirical nature of behavioral experiments allows patients to think in a more objective way.

Examination of the patient's thoughts can also lead to cognitive change. Questioning may uncover logical inconsistencies, contradictions, and other errors in thinking. Identifying cognitive distortions is in itself helpful, for patients then have specific errors to correct.

Maladaptive assumptions are usually much less accessible to patients than automatic thoughts. Some patients are able to articulate their assumptions, but most find it difficult.

Assumptions appear as themes in automatic thoughts. The therapist may ask the patient to abstract rules underlying specific thoughts. The therapist might also infer assumptions from these data and present these assumptions to the patient for verification. A patient who had trouble identifying her assumptions broke into tears upon reading an assumption inferred by her therapist—an indication of the salience of that assumption. Patients always have the right to disagree with the therapist and find more accurate statements of their beliefs.

Once an assumption has been identified, it is open to modification. This can occur in several ways: by asking the patient whether the assumption seems reasonable, by having the patient generate reasons for and against maintaining the assumption, and by presenting evidence contrary to the assumption. Even though a particular assumption may seem reasonable in a specific situation, it may appear dysfunctional when universally applied. For example, being highly productive at work is generally reasonable, but being highly productive during recreational time may be unreasonable. A physician who believed he should work to his top capacity throughout his career may not have considered the prospect of early burnout. Thus, what may have made him successful in the short run could lead to problems in the long run. Specific cognitive techniques include decatastrophizing, reattribution, redefining, and decentering.

Decatastrophizing, also known as the "what if" technique (Beck & Emery, 1985), helps patients prepare for feared consequences. This is helpful in decreasing avoidance, particularly when combined with coping plans (Beck & Emery, 1985). If anticipated consequences are likely to happen, these techniques help to identify problem-solving strategies. Decatastrophizing is often used with a time-projection technique to widen the range of information and broaden the patient's time perspective.

Reattribution techniques test automatic thoughts and assumptions by considering alternative causes of events. This is especially helpful when patients personalize or perceive themselves as the cause of events. It is unreasonable to conclude, in the absence of evidence, that another person or single factor is the sole cause of an event. Reattribution techniques encourage reality testing and appropriate assignment of responsibility by requiring examination of all the factors that impinge on a situation.

Redefining is a way to mobilize a patient who believes a problem to be beyond personal control. Burns (1985) recommends that lonely people who think, "Nobody pays any attention to me" redefine the problem as "I need to reach out to other people and be caring." Redefining a problem may include making it more concrete and specific and stating it in terms of the patient's own behavior.

Decentering is used primarily in treating anxious patients who wrongly believe they are the focus of everyone's attention. After they examine the logic behind the conviction that others would stare at them and be able to read their minds, behavioral experiments are designed to test these particular beliefs. For example, one student who was reluctant to speak in class believed his classmates watched him constantly and noticed his anxiety. By observing them instead of focusing on his own discomfort, he saw some students taking notes, some looking at the professor, and some daydreaming. He concluded that his classmates had other concerns.

The cognitive domain comprises thoughts and images. For some patients, pictorial images are more accessible and easier to report than thoughts. This is often the case with anxious patients. Ninety percent of anxious patients in one study reported visual images before and during episodes of anxiety (Beck, Laude, & Bohnert, 1974). Gathering information about imagery, then, is another way to understand conceptual systems. Spontaneous images provide data on the patient's perceptions and interpretations of events. Other specific imagery procedures used to modify distorted cognitions are discussed by Beck and Emery (1985) and by Judith Beck (1995).

In some cases, imagery is modified for its own sake. Intrusive imagery, such as imagery related to trauma, can be directly modified to reduce its impact. Patients can change

aspects of an image by "rewriting the script" of what happened, making an attacker shrink in size to the point of powerlessness or empowering themselves in the image. The point of restructuring such images is not to deny what actually happened but to reduce the ability of the image to disrupt daily functioning.

Imagery is also used in role-plays because of its ability to access emotions. Experiential techniques, such as dialogues between one's healthy self and one's negative thoughts, are used to mobilize affect and help patients both believe and feel that they have the right to be free of harmful and self-defeating patterns.

Behavioral Techniques

Cognitive therapy uses behavioral techniques to modify automatic thoughts and assumptions. It employs behavioral experiments designed to challenge specific maladaptive beliefs and promote new learning. In a behavioral experiment, for example, a patient may predict an outcome based on personal automatic thoughts, carry out the agreed-upon behavior, and then evaluate the evidence in light of the new experience.

Behavioral techniques are also used to expand patients' response repertories (skills training), to relax them (progressive relaxation) or make them active (activity scheduling), to prepare them for avoided situations (behavioral rehearsal), or to expose them to feared stimuli (exposure therapy). Because behavioral techniques are used to foster cognitive change, it is crucial to know the patient's perceptions, thoughts, and conclusions after each behavioral experiment.

Homework gives patients the opportunity to apply cognitive principles between sessions. Typical homework assignments focus on self-observation and self-monitoring, structuring time effectively, and implementing procedures for dealing with concrete situations. Self-monitoring is applied to the patient's automatic thoughts and reactions in various situations. New skills, such as challenging automatic thoughts, are also practiced as homework.

Hypothesis testing has both cognitive and behavioral components. In framing a "hypothesis," it is necessary to make it specific and concrete. A resident who insisted, "I am not a good doctor" was asked to list what was needed to arrive at that conclusion. The therapist contributed other criteria as well, for the physician had overlooked such factors as rapport with patients and the ability to make decisions under pressure. The resident then monitored his behavior and sought feedback from colleagues and supervisors to test his hypothesis, coming to the conclusion "I am a good doctor *for my level of training and experience.*"

Exposure therapy serves to provide data on the thoughts, images, physiological symptoms, and self-reported level of tension experienced by the anxious patient. Specific thoughts and images can be examined for distortions, and specific coping skills can be taught. By dealing directly with a patient's idiosyncratic thoughts, cognitive therapy is able to focus on that patient's particular needs. Patients learn that their predictions are not always accurate, and they then have the data to challenge anxious thoughts in the future.

Behavioral rehearsal and *role playing* are used to practice skills or techniques that are later applied in real life. Modeling is also used in skills training. Often role playing is videotaped so that an objective source of information is available with which to evaluate performance.

Diversion techniques, which are used to reduce strong emotions and to decrease negative thinking, include physical activity, social contact, work, play, and visual imagery.

Activity scheduling provides structure and encourages involvement. Rating (on a scale of 0 to 10) the degree of mastery and pleasure experienced during each activity of the day achieves several things: Patients who believe their depression is at a constant

level see mood fluctuations; those who believe they cannot accomplish or enjoy anything are contradicted by the evidence; and those who believe they are inactive because of an inherent defect are shown that activity involves some planning and is reinforcing in itself.

Graded-task assignment calls for the patient to initiate an activity at a nonthreatening level while the therapist gradually increases the difficulty of assigned tasks. For example, someone who has difficulty socializing might begin interacting with one other person, interact with a small group of acquaintances, or socialize with people for just a brief period of time. Step by step, the patient comes to increase the time spent with others.

Cognitive therapists work in a variety of settings. Patients are referred by physicians, schools and universities, and other therapists who believe that cognitive therapy would be especially helpful. Many patients are self-referred. The Academy of Cognitive Therapy maintains an international referral list of therapists on its Web site (www.academyofct.org).

Cognitive therapists generally adhere to 45-minute sessions. Because of the structure of cognitive therapy, much can be accomplished in this time. Patients are frequently asked to complete questionnaires, such as the BDI, before the start of each session. Most sessions take place in the therapist's office. However, real-life work with anxious patients occurs outside the therapist's office. A therapist might take public transportation with an agoraphobic, go to a pet store with a rodent phobic, or travel in an airplane with someone afraid of flying.

Confidentiality is always maintained, and the therapist obtains informed consent for audiotaping and videotaping. Such recording is used in skills training or as a way to present evidence contradicting the patient's assumptions. For example, a patient who believes she looks nervous whenever she converses might be videotaped in conversation to test this assumption. Her appearance on camera may convince her that her assumption was in error or help her to identify specific behaviors to improve. Occasionally, patients take audiotaped sessions home to review content material between sessions.

Sessions are usually conducted on a weekly basis, with severely disturbed patients seen more frequently in the beginning. Cognitive therapists give their patients phone numbers at which they can be reached in the event of an emergency.

Whenever possible, and with the patient's permission, significant others, such as friends and family members, are included in a therapy session to review the treatment goals and to explore ways in which the significant others might be helpful. This is especially important when family members misunderstand the nature of the illness, are overly solicitous, or are behaving in counterproductive ways. Significant others can be of great assistance in therapy, helping to sustain behavioral improvements by encouraging homework and assisting the patient with reality testing.

Problems may arise in the practice of cognitive therapy. For example, patients may misunderstand what the therapist says, and this may result in anger, dissatisfaction, or hopelessness. When the therapist perceives such a reaction, he or she elicits the patient's thoughts, just as with any other automatic thoughts. Together the therapist and client look for alternative interpretations. The therapist who has made an error accepts responsibility and corrects the mistake.

Problems sometimes result from unrealistic expectations about how quickly behaviors should change, from the incorrect or inflexible application of a technique, or from lack of attention to central issues. Problems in therapy require that the therapist attend to his or her own automatic thoughts and look for distortions in logic that create strong affect or prevent adequate problem solving.

Beck, Rush, et al. (1979) provide guidelines for working with difficult patients and those who have histories of unsuccessful therapy: (1) avoid stereotyping the patient as *being* the problem rather than *having* the problem; (2) remain optimistic; (3) identify

and deal with your own dysfunctional cognitions; (4) remain focused on the task instead of blaming the patient; and (5) maintain a problem-solving attitude. By following these guidelines, the therapist is able to be more resourceful with difficult patients. The therapist also can serve as a model for the patient, demonstrating that frustration does not automatically lead to anger and despair.

Evidence

Evidence-based practice in psychology (EBPP) advocates the application of empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention in the delivery of effective psychological care (APA Presidential Task Force on Evidence-Based Practice, 2006). The evidence base for any psychological treatment is evaluated in terms of its efficacy, or demonstrated causal relationship to outcome, and its utility or generalizability and feasibility—in other words, its internal and external validity. The best available research is then combined with clinical expertise in the context of patient characteristics, culture, and preferences to promote the effective practice of psychology and public health.

A fundamental component of evidence-based practice is empirically supported treatments, those demonstrated to work for a certain disorder or problem under specified circumstances. Randomized controlled trials (RCTs) in psychology, as in other health fields, are the standard for drawing causal inferences and provide the most direct and internally valid demonstration of treatment efficacy. Meta-analysis, a systematic way to synthesize results from multiple studies, is used to quantitatively measure treatment outcome and effect sizes. Other research designs, such as qualitative research and single-case experimental designs, are used to describe experiences, generate new hypotheses, and examine causal relationships for an individual, but RCTs and meta-analysis are best suited for examining whether a treatment works for a number of people.

Cognitive therapy (CT) and cognitive–behavior therapies (CBT, the atheoretical combination of cognitive and behavioral strategies) are based on empirical studies. Individual RCTs, reviews of the literature of outcome studies for a range of disorders, and meta-analyses all document the success of CT and CBT in the treatment of depression and anxiety disorders in particular (Beck, 2005; Butler, Chapman, Forman, & Beck, 2006; DeRubeis & Crits-Christoph, 1998; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Gould, Otto, & Pollack, 1995; Wampold, Minami, Baskin, & Callen Tierney, 2002). The recent review of 16 methodologically rigorous meta-analyses by Butler et al. (2006) found large effect sizes for unipolar depression, generalized anxiety disorder, panic disorder with or without agoraphobia, social phobia, and childhood depressive and anxiety disorders. Moderate effect sizes were found for marital distress, anger, childhood somatic disorders, and chronic pain. Relatively small effect sizes were found for adjunctive CBT for schizophrenia and for bulimia nervosa. Other studies have found that CT/CBT yields lower relapse rates than antidepressant medications (Hollon, DeRubeis, Shelton, et al., 2005) and reduces the risk of symptoms returning following treatment termination for depression and anxiety disorders (Hollon, Stewart, & Strunk, 2006).

One criticism of the reliance on RCTs in psychotherapy research is that the samples studied are so carefully screened to eliminate comorbidity or other threats to experimental control that they do not represent real groups in the community, who often have multiple problems. However, a recent study by Brown et al. (2005) showed success for cognitive therapy for the prevention of suicide attempts among people at high risk for suicide. The participants in this study had more than one psychiatric diagnosis, and 68% had substance abuse problems. A study by DeRubeis et al. (2005) similarly included participants with comorbidity.

In addition to best available research, another component of evidence-based practice is clinical expertise—the advanced clinical skills to assess, diagnose, and treat disorders. The importance of clinical expertise is demonstrated in the study by DeRubeis et al. (2005), which concluded that CT can be as effective as medications for the initial treatment of depression, but the degree of effectiveness may depend on a high level of therapist experience or expertise.

The generalizability of CT/CBT has been examined in a few studies. Stirman and colleagues (Stirman, DeRubeis, Crits-Cristoph & Rothman, 2005) found that clinical characteristics of subjects in RCTs matched those of patients in clinical settings. Similarly, Persons and associates (Persons, Bostrom, & Bertagnolli, 1999) found that clinic patients treated with CT for depression improved comparably to those in RTCs. In addition, studies of schizophrenic patients at National Health Service clinics in the U.K. found improved symptoms using CT as an adjunct to pharmacotherapy (Tarrier, 2008).

Because training in evidence-based therapies has been mandated by the Accreditation Council for Graduate Medical Education, CT/CBT is being taught in psychiatry residency programs in the United States. As the number of professionals with expertise in cognitive therapy increases, research may be further directed both toward refining the therapy for more populations in need and toward exploring ways to make it cost-effective and available in community settings.

Psychotherapy in a Multicultural World

Cognitive therapy begins with an understanding of the patient's beliefs, values and attitudes. These exist within a cultural context, and the therapist must understand that context. Cognitive therapy focuses on whether these beliefs are adaptive for the patient, and whether they pose difficulties or lead to dysfunctional behavior. Cognitive therapy does not work on changing beliefs in an arbitrary way, nor is it an attempt to impose the therapist's beliefs on the patient. Rather, it helps the individual examine his or her own beliefs and whether they foster emotional well-being. Sometimes people's personal beliefs are at odds with the cultural values around them. Other times, a person's beliefs may be changing with culture change, as in rapid modernization or migration to a new country, and discrepancies may cause distress. In these cases, cognitive therapy may help patients think flexibly in order to reconcile their beliefs with environmental constraints or empower them to find solutions.

Beck's work has been translated into more than a dozen languages, and cognitive therapists are represented by organizations worldwide. Research in cognitive therapy has been conducted in many countries, primarily industrial economies. There is a need to expand cognitive therapy research further into developing nations.

CASE EXAMPLE

This case example of the course of treatment for an anxious patient illustrates the use of both behavioral and cognitive techniques.

Presenting Problem

The patient was a 21-year-old male college student who complained of sleep-onset insomnia and frequent awakenings, halting speech and stuttering, shakiness, feelings of nervousness, dizziness, and worrying. His sleep difficulties were particularly acute prior to exams or athletic competitions. He attributed his speech problems to his search for the "perfect word."

The patient was raised in a family that valued competition. As the eldest child, he was expected to win all the contests. His parents were determined that their children should surpass them in achievements and successes. They so strongly identified with the patient's achievements that he believed, "My success is their success."

The patient was taught to compete with other children outside the family as well. His father reminded him, "Never let anyone get the best of you." As a consequence of viewing others as adversaries, he developed few friends. Feeling lonely, he tried desperately to attract friends by becoming a prankster and by telling lies to enhance his image and make his family appear more attractive. Although he had acquaintances in college, he had few friends, for he was unable to self-disclose, fearing that others would discover he was not all that he would like to be.

Early Sessions

After gathering initial data regarding diagnosis, context, and history, the therapist attempted to define how the patient's cognitions contributed to his distress (T = Therapist; P = Patient).

T: What types of situations are most upsetting to you?
P: When I do poorly in sports, particularly swimming. I'm on the swim team. Also, if I make a mistake, even when I play cards with my roommates. I feel really upset if I get rejected by a girl.
T: What thoughts go through your mind, let's say, when you don't do so well at swimming?
P: I think people think much less of me if I'm not on top, a winner.
T: And how about if you make a mistake playing cards?
P: I doubt my own intelligence.
T: And if a girl rejects you?
P: It means I'm not special. I lose value as a person.
T: Do you see any connections here, among these thoughts?
P: Well, I guess my mood depends on what other people think of me. But that's important. I don't want to be lonely.
T: What would that mean to you, to be lonely?
P: It would mean there's something wrong with me, that I'm a loser.

At this point, the therapist began to hypothesize about the patient's organizing beliefs: that his worth is determined by others, that he is unattractive because there is something inherently wrong with him, that he is a loser. The therapist looked for evidence to support the centrality of these beliefs and remained open to other possibilities.

The therapist assisted the patient in generating a list of goals to work on in therapy. These goals included (1) decreasing perfectionism, (2) decreasing anxiety symptoms, (3) decreasing sleep difficulties, (4) increasing closeness in friendships, and (5) developing his own values apart from those of his parents. The first problem addressed was anxiety. An upcoming exam was chosen as a target situation. This student typically studied far beyond what was necessary, went to bed worried, finally fell asleep, woke during the night thinking about details or possible consequences of his performance, and went to exams exhausted. To reduce ruminations about his performance, the therapist asked him to name the advantages of dwelling on thoughts of the exam.

P: Well, if I don't think about the exam all the time I might forget something. If I think about the exam constantly, I think I'll do better. I'll be more prepared.
T: Have you ever gone into a situation less "prepared"?

P: Not an exam, but once I was in a big swim meet and the night before I went out with friends and didn't think about it. I came home, went to sleep, got up, and swam.
T: And how did it work out?
P: Fine. I felt great and swam pretty well.
T: Based on that experience, do you think there's any reason to try to worry less about your performance?
P: I guess so. It didn't hurt me not to worry. Actually, worrying can be pretty distracting. I end up focusing more on how I'm doing than on what I'm doing.

The patient came up with his own rationale for decreasing his ruminations. He was then ready to consider giving up his maladaptive behavior and risk trying something new. The therapist taught the patient progressive relaxation, and the patient began to use physical exercise as a way to relieve anxiety.

The patient was also instructed in how cognitions affect behavior and mood. Picking up on the patient's statement that worries can be distracting, the therapist proceeded.

T: You mentioned that when you worry about your exams, you feel anxious. What I'd like you to do now is imagine lying in your bed the night before an exam.
P: Okay, I can picture it.
T: Imagine that you are thinking about the exam and you decide that you haven't done enough to prepare.
P: Yeah, OK.
T: How are you feeling?
P: I'm feeling nervous. My heart is beginning to race. I think I need to get up and study some more.
T: Good. When you think you're not prepared, you get anxious and want to get up out of bed. Now, I want you to imagine that you are in bed the night before the exam. You have prepared in your usual way and are ready. You remind yourself of what you have done. You think that you are prepared and know the material.
P: OK. Now I feel confident.
T: Can you see how your thoughts affect your feelings of anxiety?

The patient was instructed to record automatic thoughts, recognize cognitive distortions, and respond to them. For homework, he was asked to record his automatic thoughts if he had trouble falling asleep before an exam. One automatic thought he had while lying in bed was "I should be thinking about the exam." His response was "Thinking about the exam is not going to make a difference at this point. I did study." Another thought was "I must go to sleep now! I must get eight hours of sleep!" His response was "I have left leeway, so I have time. Sleep is not so crucial that I have to worry about it." He was able to shift his thinking to a positive image of himself floating in clear blue water.

By observing his automatic thoughts across a variety of situations—academic, athletic, and social—the patient identified dichotomous thinking (e.g., "I'm either a winner or a loser") as a frequent cognitive distortion. Perceiving the consequences of his behavior as either totally good or completely bad resulted in major shifts in mood. Two techniques that helped with his dichotomous thinking were reframing the problem and building a continuum between his dichotomous categories.

Here the problem is reframed:

T: Can you think of reasons for someone not to respond to you other than because you're a loser?
P: No. Unless I really convince them I'm great, they won't be attracted.

T: How would you convince them of that?
P: To tell you the truth, I'd exaggerate what I've done. I'd lie about my grade point average or tell someone I placed first in a race.
T: How does that work out?
P: Actually, not too well. I get uncomfortable and they get confused by my stories. Sometimes they don't seem to care. Other times they walk away after I've been talking a lot about myself.
T: So in some cases, they don't respond to you when you focus the conversation on yourself.
P: Right.
T: Does this have anything to do with whether you're a winner or a loser?
P: No, they don't even know who I am deep down. They're just turned off because I talk too much.
T: Right. It sounds like they're responding to your conversational style.

The therapist reframed the problem from a situation in which something was inherently wrong with the patient to one characterized by a problem of social skills. Moreover, the theme "I am a loser" appeared so powerful to the patient that he labeled it as his "main belief." This assumption was traced historically to the constant criticism from his parents for mistakes and perceived shortcomings. By reviewing his history, he was able to see that his lies prevented people from getting closer, reinforcing his belief that they didn't want to be close. In addition, he believed that his parents made him whatever success he was and that no achievement was his alone. This had made him angry and lacking in self-confidence.

Later Sessions

As therapy progressed, the patient's homework increasingly focused on social interaction. He practiced initiating conversations and asking questions in order to learn more about other people. He also practiced "biting his tongue" instead of telling small lies about himself. He monitored people's reactions to him and saw that they were varied, but generally positive. By listening to others, he found that he admired people who could openly admit shortcomings and joke about their mistakes. This experience helped him understand that it was useless to categorize people, including himself, as winners and losers.

In later sessions, the patient described his belief that his behavior reflected on his parents, and vice versa. He said, "If they look good, it says something about me and if I look good, they get the credit." One assignment required him to list the ways in which he was different from his parents. He remarked, "Realizing that my parents and I are separate made me realize I could stop telling lies." Recognizing how he was different from his parents freed him from their absolute standards and allowed him to be less self-conscious when interacting with others.

Subsequently, the patient was able to pursue interests and hobbies that had nothing to do with achievement. He was able to set moderate and realistic goals for schoolwork, and he began to date.

SUMMARY

Cognitive therapy has grown quickly because of its empirical basis and demonstrated efficacy. Borrowing some of its concepts from cognitive theorists and a number of techniques from behavior therapy and client-oriented psychotherapy, cognitive therapy

consists of a broad theoretical structure of personality and psychopathology, a set of well-defined therapeutic strategies, and a wide variety of therapeutic techniques. Similar in many ways to rational emotive behavior therapy, which preceded but developed parallel to cognitive therapy, this system of psychotherapy has acquired strong empirical support for its theoretical foundations. A number of outcome studies have demonstrated its efficacy, especially in the treatment of depression. The related theoretical formulations of depression have been supported by more than 100 empirical studies. Other concepts, such as the cognitive triad in depression, the concept of specific cognitive profiles for specific disorders, cognitive processing, and the relationship of hopelessness to suicide, have also received strong support.

Outcome studies have investigated cognitive therapy with major depressive disorders, generalized anxiety disorder, dysthymic disorder, drug abuse, alcoholism, panic disorder, anorexia, and bulimia. In addition, cognitive therapy has been applied successfully to the treatment of obsessive–compulsive disorder, hypochondriasis, and various personality disorders. In conjunction with psychotropic medication, it has been used to treat delusional disorders and bipolar disorder.

Much of the popularity of cognitive therapy is attributable to strong empirical support for its theoretical framework and to the large number of outcome studies with clinical populations. In addition, there is no doubt that the intellectual atmosphere of the "cognitive revolution" has made the field of psychotherapy more receptive to this new therapy. A further attractive feature of cognitive therapy is that it is readily teachable. The various therapeutic strategies and techniques have been described and defined in such a way that one year's training is usually sufficient for a psychotherapist to attain a reasonable level of competence as a cognitive therapist.

Although cognitive therapy focuses on understanding the patient's problems and applying appropriate techniques, it also attends to the nonspecific therapeutic characteristics of the therapist. Consequently, the basic qualities of empathy, acceptance, and personal regard are highly valued.

Because therapy is not conducted in a vacuum, cognitive therapists pay close attention to patients' interpersonal relations and confront patients continuously with problems they may be avoiding. Further, therapeutic change can take place only when patients are emotionally engaged with their problems. Therefore, the experience of emotion during therapy is a crucial feature. The patient's reactions to the therapist, and the therapist's to the patient, are also important. Excessive and distorted responses to the therapist are elicited and evaluated just like any other type of ideational material. In the presence of the therapist, patients learn to correct their misconceptions, which were often derived from early experiences.

Cognitive therapy may offer an opportunity for a rapprochement between psychodynamic therapy and behavior therapy. In many ways it provides a common ground for these two disciplines. At the present time, the number of cognitive therapists within the behavior therapy movement is growing. In fact, many behavior therapists view themselves as cognitive–behavior therapists.

Looking to the future, it is anticipated that the boundaries of the theoretical background of cognitive therapy will gradually expand to encompass or penetrate the fields of cognitive psychology and social psychology. There is already an enormous amount of interest in social psychology, which provides the theoretical background of cognitive therapy.

In an era of cost containment, this short-term approach will prove to be increasingly attractive to third-party payers as well as to patients. Future empirical studies of its processes and effectiveness will undoubtedly be conducted to determine whether cognitive therapy can fulfill its promise.

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