Name- Goehler

Reading Guide for #1 for 2nd third of the semester
Interpersonal communication: theories of helping (person centered)

In preparation for the class discussions, please complete the following before class.

+4

Look over Parsons Ch. 13 (p. 191-194) & Supplement #1 (*A Client-centered Approach in Therapy* by Carl Rogers)

1. What will you learn about in this reading guide?

Interpersonal Comm. Client centered/Humanistic theories of helping.

Read Parsons Ch. 13 (p. 191-194)

Pages 191-193 (at the top of the page)

1. Explain the following: "Theories provide a structure within which to understand the data being presented (by the helpee) and what path to follow" (p. 191). The amount of info the helper must consider can be overwhelming without the framework of theories that help organize the info and assist the helpee.

2. In light of the puzzle analogy offered by Parsons on p. 192, how do theories assist helpers? They provide a framework of what to expect / a clearer goal of what help is necessary - and how to evaluate progress — to completion.

3. List the 3 theories that will be discussed in this chapter of the Parsons book. Psychoanalytic - (understanding the helpees early life history) / Person-centered Phenomenological = (Humanistic approach helping self-discovery) / Behavioral - Cognitive = (teaching - learning modification of behavior).

Read Parsons Ch. 13 (p. 195)

1. What is the name of the person who created the person-centered theory of helping? Carl Rogers = focuses on the uniqueness of each helpee. emphasis on hear and now. (Humanistic approach)
2. How does person-centered theory explain both an emotionally healthy and emotionally unhealthy person? human beings - when functioning as they should - are constructive and growth-oriented. Otherwise, they're merely "blocked somehow" and need help getting in touch with their potential and "natural tendency toward healthy, growth filled decision making
3. What is the role of a helper who is using a person-centered approach to helping?

A FACILITATOR; assisting self discovery.

The emphasis is given to the nature of the relationship.

Name- Goehler

4. What does a helper do if he/she is using a person-centered approach to helping?
Provide the helpee with a genuine, nonjudgemental, and open encounter.

Read supplement #1 (*A Client-centered Approach in Therapy* by Carl Rogers pages 135-139)

1. Briefly describe the central hypothesis of the person-centered approach to helping. People are rational. The role of the helper is simply to create the psychological climate that encourages the helpee to get in touch with their healthy tendency -

The first condition that promotes growth in the helpee is genuineness, realness, or congruence.

1. Explain this condition. non-direction permits Trust in the relationship

2. If you were a helpee, how do you believe you would respond to this condition? It may be helpful to think of a time when someone demonstrated this condition to you. Trusting the helper is really interested in the development of helpees', permits the self-exploration necessary to express and reflect upon to grow.

3. If you were a helper, how would you feel/what would you think about using this condition? Coaching others through presenting opportunities of self-expression/reflection, is what the Learning Cycle is all about.

The second condition that promotes growth in the helpee is acceptance, caring, ~~or prizing~~.

1. Explain this condition. non judgmental permits Trust in the relationship.

2. If you were a helpee, how do you believe you would respond to this condition? It may be helpful to think of a time when someone demonstrated this condition to you. I'd respond by Being Authentic.

3. If you were a helper, how would you feel/what would you think about using this condition? I'd think "God help us", as initially the garbage is on the surface of aberrated Thoughts needing to be "expressed".

Name- Gaehler

The third condition that promotes growth in the helpee is empathic understanding.

1. Explain this condition. Sensing the feelings of others

2. If you were a helpee, how do you believe you would respond to this condition? It may be helpful to think of a time when someone demonstrated this condition to you. Understanding the helper genuinly understands the process — promotes trust to be co-operative.

3. If you were a helper, how would you feel/what would you think about using this condition? I - C - U!
The helper ultimately must assure the helpee that there is Understanding in the relationship

Pages 136-137 discuss trust. What is the connection between trust and the self actualizing tendency?
Understanding the actualizing tendency present in every being, A helper simply permits the opportunity — Trusting the process.

On pages 137 & 138, Carl Rogers describes one more characteristic that promotes growth. In this section, he refers to a spiritual & mystical experience that occurs when he is helping. I recommend reading this section at least twice.

1. What does he mean by the statement "Then simply my presence is releasing and helpful?" We are all in this game of life together — and just Being There in the Now "transcends" all the other mental noise/problems.

2. Explain the spiritual/mystical experience that Rogers says occurs during helping. Connection with the moment is why its called the "Present". Present Time experience is phenomenal — when most everyone is hardly ever There & Now.

Read the paragraph on page 138 that begins "The person-centered approach, then, is primarily a way of being…"

1. What is interesting about this paragraph to you?
Creating a growth-promoting climate helps others become empowered — toward personal and social transformation-
"What's interesting about this" is the idea a person expands into personal capicity — regulated by the Cult-ural paradigm.

Name- Goehler

2. What is unclear to you in this paragraph?

Where to draw the line on free expression of the individual. Aberration is contagious — and at some point, cancer treatment prevents the spread of cancer — Much like prisons prevent crime waves.

Connecting to previous semester content:

1. Look back at previous material related to facilitative attitudes and the helping relationship. How do these concepts connect with the person-centered approach to helping?

Non Judging / Non Direction promotes a Trust in a Coaching process in the person-centered approach helping individuals / groups realize their potential.

2. Look back at previous material related to non-directive coaching. How does this concept connect with the person-centered approach to helping?

non-direction coaching is based upon promoting independent problem solving skills — Trusting that the helpee will get in touch with their healthy tendency.

3. List other topics from the first part of the semester that relate to the person-centered approach to helping

Self awareness / Empathy, Motivation, Beliefs, values, biases, cultural framework / worldview, Emotional intelligence, Belongingness, facilitative attitudes, Experiential Learning Cycles, Learning Styles, S.M.A.R.T. Goals, G.R.O.W. Model,

Do not leave this blank. If you understand everything you read, you should still have questions you are wondering about as it relates to the reading. What 1-2 questions do you have for clarification or extension of the reading you completed in this reading guide? If you do not have any questions, feel free to make comments about your thoughts or opinions regarding the reading and how it applies to your life.

Yes... Humanism rejects super-naturalism and stresses an individuals dignity, worth and capacity for self-realization through reason. Im all for it! Lets reject the supernatural insanities and handle Naturalism as it is: Scientific laws are adequate to account for all phenomena!

Name- COEMLER

Reading Guide #2 for 2nd third of the semester
Interpersonal communication: theories of helping (cognitive/behavioral)

In preparation for the class discussions, please complete the following before class.

Look over Parsons Ch. 13 (p. 195-196) & pages 1-9 in Supplement #2 (*Cognitive Therapy* by Judith Beck)

1. What will you learn about in this reading guide?

COGNITIVE / BEHAVIORAL THEORIES OF HELPING

+4

Read Parsons Parsons Ch. 13 (p. 195-196)

1. Explain the role of learning in behavioral/cognitive approaches to helping. "learning" behavior once identified – can be re"learned".

2. Explain the role of the environment in behavioral/cognitive approaches to helping. With its rewards and punishment incentives behavior can be validated or modified.

3. Put the following into your own words: These are the 4 areas that cognitive/behavioral approaches emphasize:

A. Identification of the current influences on the helpee, rather than the historical determinants

Thoughts become actions – so its necessary to determine the influencing factors involved causing problems.

B. Specific identification of problem and goals of helping

Once "Problems" are specified, goals may be considered.

C. The importance of observable, behavioral change Small goals validate efforts toward larger goal of behavioral changes.

D. A scientific, empirical approach to helping Helping must be observable by the helpee otherwise helping appears more like controlling.

4. Put the following into your own words: These are the areas that cognitive approaches emphasize:

A. Understand the connection between the way he/she thinks about him-/herself and his/her world, and the way he/she acts and feels

Its all about the helpee's rehabilitation of Responsibility to observe self and thoughts involved in interaction

Name- Goehler

B. Identify when his/her thinking is based on faulty logic and assumptions

The helpee observes effect which certain Thinking causes

C. Learn to challenge and correct the distorted, faulty thinking

The helpee can be coached to consider old/new thinking

Read pages 1-9 in Supplement #2 (*Cognitive Therapy* by Judith Beck, the daughter of Aaron Beck)

Page 1-3

1. According to cognitive therapy, which is frequently called CBT (cognitive behavioral therapy), what is the common problem of people experiencing psychological difficulties? Distorted/Dysfunctional Thinking — which influences Mood and behavior.

2. List 10 psychological problems that can be effectively treated with cognitive therapy. Depression, Anxiety, panic, social phobia, substance abuse, eating disorders, couples problems, obsessive-compulsive disorder, PTS, hypochondria, schizophrenia —

Pages 3-4

1. Concisely summarize the conversation between Sally and her therapist. Applying CBT, the therapist elicits Sally's Narrative Identity to discover/expose distorted thinking, which Sally learns to observe/consider for herself - wherein self-development prompts a GROW model resolution

Pages 5-9

Describe each of the 10 principles of cognitive behavioral therapy:

1. Cognitive therapy is based on an ever-evolving formulation of the patient and her problems in cognitive terms.

noting behavioral "problems" both flow from and in turn reinforce dysfunctional thinking, a helpee simply formulates CONFRONTING conceptualizations and re-consider adaptive responces.

2. Cognitive therapy requires a sound therapeutic alliance.

Trust is required for a genuine relationship

Name- Goehler

3. Cognitive therapy emphasizes collaboration and active participation.

Relationships require mutual co-operation.

4. Cognitive therapy is goal oriented and problem focused. Problem identification presents an opportunity to evaluate the validity of thought/belief/biases, and then re-consider GROW options.

5. Cognitive therapy initially emphasizes the present PTP's (Present Time Problems) must be foremost in achieving Cognitive awareness, CAUSE/EFFECT scenarios related to evaluating validity of beliefs

6. Cognitive therapy is educative, aims to teach the patient to be her own therapist, and emphasizes relapse prevention.

Learning how to notice what one doesn't notice helps one notice what one hasn't been noticing. Cognitive therapy developes self-awareness and ideally teaches methods of being responsible for thoughts/behaviors

7. Cognitive therapy aims to be time limited.

Most insurance policies limit the number of sessions for symptom relief. If therapy focused on teaching tools to be responsibly self aware, the therapist would soon be unemployed.

8. Cognitive therapy sessions are structured.

Its always about PTP's and the ability of handling PTP's and/or developing skills of handling PTP's toward self-therapy.

9. Cognitive therapy teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs.

Socratic questioning developes collaborative empiricism, i.e. facilitates the Experiential Learning Cycle, and GROW model methods of response-ability.

10. Cognitive therapy uses a variety of techniques to change thinking, mood, and behavior.

Neuroplasticity re-forms. Synaptic pruning is a process. But in a nut-shell, the process merely involves Observation and re-Consideration of Thoughts prompting particular behavior

Reading Application

1. If you were a helpee, how do you believe you would respond to CBT? It may be helpful to think of a time when someone demonstrated this condition to you. Be specific. What aspects would you respond well to? What aspects would you not respond as well to?

I'd respond well or not well in accord with the helpers aptitude to handling the case.

Name- Goehler

2. If you were a helper, how would you feel/what would you think about using a CBT approach to helping?

Identifying PTP is all a "helper" does to help helpees learn how to handle them themselves. Otherwise whats the use of Carl Rogers Person-centered approach to therapy?

Connecting to previous learning

1. How would you compare CBT to a person-centered approach? Think of similarities and differences.

People inherently know and desire the best, CBT similarities permit the helpee to discover Thoughts/Behaviors with strategic questioning, whereas its different in considering GROW model applications

2. How do facilitative attitudes and the helping relationship connect to CBT?

Trust is paramount - helpees must trust the helper
1- values the helpee
2- appears adept as helper.

3. How does non-directive coaching relate to CBT?

Coaching NUDGES attention to "consider for itself" thus develope helpee self-determinism

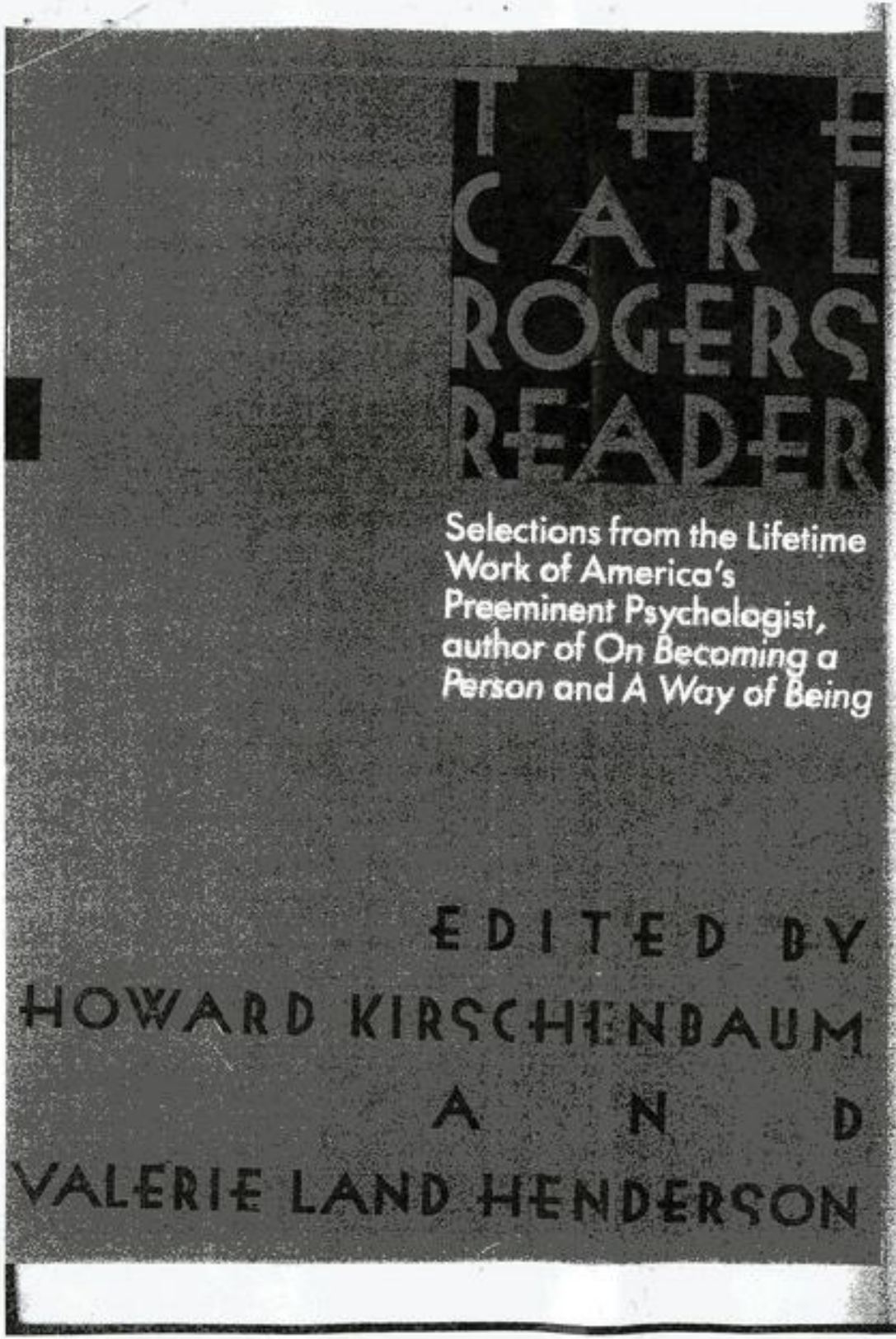
4. How do multiple intelligences and learning styles relate to CBT?

Understanding MI & LS permits the helpee to strategically appeal to streangths of helpee

5. List other topics from the first part of the semester that relate to CBT. Narative Identity experiential learning cycle, relationship between beliefs values attitudes and behaviors Emotional Intelligence, neuroplasticity, Assertive-passive comm. Conflict resolution, GROW model, SMART goal setting.

Do not leave this blank. If you understand everything you read, you should still have questions you are wondering about as it relates to the reading. What 1-2 questions do you have for clarification or extension of the reading you completed in this reading guide? If you do not have any questions, feel free to make comments about your thoughts or opinions regarding the reading and how it applies to your life.

Understanding/Mis-understandings are the cause and solution of problems and mis behaviors. Or as Thomson sez: Awareness + Responsibility = Performance. CBT... in this day and age of dysfunctional families producing a draconian police state — sadly seems in-demand, in this Simon-sez game of socialism. CRIMESOLUTIONS.GOV reveals CBT can deter crime, assist victims and prevent recidivism. Check it out.



Supplement #1

10
A Client-centered/Person-centered Approach to Therapy

What do I mean by a client-centered, or person-centered, approach? For me it expresses the primary theme of my whole professional life, as that theme has become clarified through experience, interaction with others, and research. This theme has been used and found effective in many areas, until the broad label "a person-centered approach" seems the most descriptive.

The central hypothesis of this approach can be briefly stated. It is that the individual has within himself or herself vast resources for self-understanding, for altering his or her self-concept, attitudes, and self-directed behavior—and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided.

There are three conditions that constitute this growth-promoting climate, whether we are speaking of the relationship between therapist and client, parent and child, leader and group, teacher and student, or administrator and staff. The conditions apply, in fact, in any situation in which the development of the person is a goal. I have described these conditions at length in previous writings (Rogers, 1959, 1961). I present here a brief summary from the point of view of psychotherapy, but the description applies to all the foregoing relationships.

The first element is genuineness, realness, or congruence. The more the therapist is himself or herself in the relationship, putting up no professional front or personal façade, the greater is the likelihood that the client will change and grow in a constructive manner. Genuineness means that the therapist is openly being the feelings and attitudes that are flowing within at the moment. There is a close matching, or congruence, between what is being experienced at the gut level, what is present in awareness, and what is expressed to the client.

The second attitude of importance in creating a climate for

In Kutash, I. and Wolf, A. (Eds.), *Psychotherapist's Casebook*. Jossey-Bass, 1986. 197–208.

change is acceptance, or caring, or prizing—unconditional positive regard. When the therapist is experiencing a positive, nonjudgmental, accepting attitude toward whatever the client *is* at that moment, therapeutic movement or change is more likely. Acceptance involves the therapist's willingness for the client to be whatever immediate feeling is going on—confusion, resentment, fear, anger, courage, love, or pride. It is a nonpossessive caring. When the therapist prizes the client in a total rather than a conditional way, forward movement is likely.

The third facilitative aspect of the relationship is empathic understanding. This means that the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this acceptant understanding to the client. When functioning best, the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness. Listening, of this very special, active kind, is one of the most potent forces for change that I know.

There is a body of steadily mounting research evidence that, by and large, supports the view that when these facilitative conditions are present, changes in personality and behavior do indeed occur. Such research has been carried on in this and other countries from 1949 to the present. Studies have been made of changes in attitude and behavior in psychotherapy, in degree of learning in school, and in the behavior of schizophrenics. In general, they are confirming. (See Rogers, 1980, for a summary of the research.)

Trust

Practice, theory, and research make it clear that the person-centered approach is built on a basic trust in the person. This is perhaps its sharpest point of difference from most of the institutions in our culture. Almost all of education, government, business, much of religion, much of family life, much of psychotherapy, is based on a distrust of the person. Goals must be set, because the person is seen as incapable of choosing suitable aims. The individual must be guided toward these goals, since otherwise he or she might stray from the selected path. Teachers, parents, supervisors must develop procedures to make sure the individual is progressing toward the goal—examinations, inspections, interrogations. The individual is seen as innately sinful, destructive, lazy, or all three—as someone who must be constantly watched over.

The person-centered approach, in contrast, depends on the actualizing tendency present in every living organism—the tendency to grow, to develop, to realize its full potential. This way of being trusts the constructive directional flow of the human being toward a more complex and complete development. It is this directional flow that we aim to release.

One More Characteristic

I described above the characteristics of a growth-promoting relationship that have been investigated and supported by research. But recently my view has broadened into a new area that cannot as yet be studied empirically.

When I am at my best, as a group facilitator or a therapist, I discover another characteristic. I find that when I am closest to my inner, intuitive self, when I am somehow in touch with the unknown in me, when perhaps I am in a slightly altered state of consciousness in the relationship, then whatever I do seems to be full of healing. Then simply my *presence* is releasing and helpful. There is nothing I can do to force this experience, but when I can relax and be close to the transcendental core of me, then I may behave in strange and impulsive ways in the relationship, ways which I cannot justify rationally, which have nothing to do with my thought processes. But these strange behaviors turn out to be *right*, in some odd way. At those moments it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself and becomes a part of something larger. Profound growth and healing and energy are present.

This kind of transcendent phenomenon is certainly experienced at times in groups in which I have worked, changing the lives of some of those involved. One participant in a workshop put it eloquently: "I found it to be a profound spiritual experience. I felt the oneness of spirit in the community. We breathed together, felt together, even spoke for one another. I felt the power of the 'life force' that infuses each of us—whatever that

is. I felt its presence without the usual barricades of 'me-ness' or 'you-ness'—it was like a meditative experience when I feel myself as a center of consciousness. And yet with that extraordinary sense of oneness, the separateness of each person present has never been more clearly preserved."

I realize that this account partakes of the mystical. Our experiences, it is clear, involve the transcendent, the indescribable, the spiritual. I am compelled to believe that I, like many others, have underestimated the importance of this mystical, spiritual dimension.

In this I am not unlike some of the more advanced thinkers in physics and chemistry. (For example, see Capra, 1982.) As they push their theories further, picturing a "reality" which has no solidity, which is no more than oscillations of energy, they too begin to talk in terms of the transcendent, the indescribable, the unexpected—the sort of phenomena that we have observed and experienced in the person-centered approach.

The person-centered approach, then, is primarily a way of being that finds its expression in attitudes and behaviors that create a growth-promoting climate. It is a basic philosophy rather than simply a technique or a method. When this philosophy is lived, it helps the person expand the development of his or her own capacities. When it is lived, it also stimulates constructive change in others. It empowers the individual, and when this personal power is sensed, experience shows that it tends to be used for personal and social transformation.

When this person-centered way of being is lived in psychotherapy, it leads to a process of self-exploration and self-discovery in the client and eventually to constructive changes in personality and behavior. As the therapist lives these conditions in the relationship, he or she becomes a companion to the client in this journey toward the core of self. This process is, I believe, illuminated in the case material that follows.

JAN—AND THE PROCESS OF CHANGE

Occasionally one interview will illustrate several aspects of the therapeutic process as it occurs in the changing relationship between therapist and client. Such an interview was the one I held

with Jan. It was a half-hour demonstration therapy session, held onstage before a workshop of six hundred participants in Johannesburg, South Africa.

Several individuals had volunteered, and the next morning, shortly before the interview, my colleague Ruth Sanford told Jan that she had selected her as the client.

Jan and I took chairs facing each other, so that the audience had a side view of our interaction. We adjusted and tried out our microphones. Then I said that I wished a few moments of quiet to collect myself and get centered. I added that she might also like that time to become quiet, and a nod of her head indicated that she would. I used the time to forget the technicalities and to focus my mind on being present to Jan and open to anything she might express.

From this point on, the material is taken from the recorded interview. The excerpts given contain the main themes and significant points. The material omitted consists of further explication of some theme or the pursuit of some issue that was dropped.

The reader will find it profitable, I believe, to first read the interview as a whole, looking only at what Jan and I said, and skipping over the comments on the process that are interspersed from time to time. A second reading can then be done by segments, stopping to consider the comments on each segment.

CARL: Now I feel more ready. I don't know what you want to talk with me about, because we haven't done more than say hello to each other. But whatever you would like to bring up, I'd be very ready to hear. (*Pause.*)

JAN: I have two problems. The first one is the fear of marriage and children. And the other one is the age process, aging. It's very difficult to look into the future, and I find it very frightening.

CARL: Those are two main problems for you. I don't know which you'd rather pick up first.

JAN: I think the immediate problem is the age problem. I would rather start on it. If you can help on that, I would be very grateful.

CARL: Can you tell me a little bit more about the fear that you have of aging? As you get older, what?

Cognitive Therapy

Basics and Beyond

Judith S. Beck

Foreword by Aaron T. Beck

Supplement #2

Chapter 1

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

T: And how does that make you feel?

P: Sad. Really low.

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

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

T: Okay. What else?

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

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

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

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

P: I did work last year. And that was on top of school and other activities. But this year . . . I just don't know.

T: Any other evidence that you could handle a job?

P: I don't know. . . . It's possible I could do something that doesn't take much time. And that isn't too hard.

T: What might that be?

P: A sales job maybe. I did that last year.

T: Any ideas of where you could work?

P: Actually, maybe The [University] Bookstore. I saw a notice that they're looking for new clerks.

T: Okay. And what would be the *worst* that could happen if you did get a job at the bookstore?

P: I guess if I couldn't do it.

T: And you'd live through that?

P: Yeah, sure. I guess I'd just quit.

T: And what would be the *best* that could happen?

P: Uh . . . that I'd be able to do it easily.

T: And what's the most *realistic* outcome?

P: It probably won't be easy, especially at first. But I might be able to do it.

T: What's the effect of believing this original thought, "I won't be able to handle a job."

P: Makes me feel sad. . . . Makes me not even try.

T: And what's the effect of changing your thinking, of realizing that possibly you could work in the bookstore?

P: I'd feel better. I'd be more likely to apply for the job.

T: So what do you want to do about this?

P: Go to the bookstore. I could go this afternoon.

T: How likely are you to go?

P: Oh, I guess I will. I will go.

T: And how do you feel now?

P: A little better. A little more nervous, maybe. But a little more hopeful, I guess.

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

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

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

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

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

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

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

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

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

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

Principle No. 5. Cognitive therapy initially emphasizes the present. The treatment of most patients involves a strong focus on current problems and on specific situations that are distressing to the patient. Resolution and/or a more realistic appraisal of situations that are currently distressing usually lead to symptom reduction. The cognitive therapist, therefore, generally tends to start therapy with an examination of here-and-now problems, regardless of diagnosis. Attention shifts to the past in three circumstances: when the patient expresses a strong predilection to do so; when work directed toward current problems produces little or no cognitive, behavioral, and emotional change; or when the therapist judges that it is important to understand how and when important dysfunctional ideas originated and how these ideas affect the patient today. Sally's therapist, for example, discusses childhood events with her midway through therapy to help her identify a set of beliefs she learned as a child: "If I achieve highly, it means I'm an okay person," and "If I don't achieve highly, it means I'm a failure." Her therapist helps her evaluate the validity of these beliefs both in the past and present. Doing so leads Sally, in part, to the development of more functional, more reasonable beliefs. If Sally had had a personality disorder, her therapist would have spent proportionally more time discussing her developmental history and childhood origin of beliefs and coping behaviors.

Observe PTP

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

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

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

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

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

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

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

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

DEVELOPING AS A COGNITIVE THERAPIST

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

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

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

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

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

HOW TO USE THIS BOOK

This book is intended for individuals at any stage of experience and skill development who lack mastery in the fundamental building blocks of cognitive conceptualization and treatment. It is critical to have mastered the basic elements of cognitive therapy in order to understand how and when to vary standard treatment for individual patients.

Your growth as a cognitive therapist will be enhanced if you start applying the tools described in this book to yourself. First, as you read, begin to conceptualize your own thoughts and beliefs. In the next chapter, you will learn more about the cognitive model: How you feel emotionally at a given time (and how you react physically and behaviorally) is influenced by how you perceive a situation and specifically by what is going through your mind. As of right now, start attending to your own shifts in affect. When you notice that your mood has changed or intensified in a negative direction or when you notice bodily sensations associated with negative affect, ask yourself what emotion you are experiencing, as well as the cardinal question of cognitive therapy:

> What was just going through my mind?

In this way, you will teach yourself to identify your own thoughts, specifically your "automatic thoughts," which are explained further in the next chapter. Teaching yourself the basic skills of cognitive therapy using yourself as the subject will enhance your ability to teach your patients these same skills.

It will be particularly useful to identify your automatic thoughts as you are reading this book and trying techniques with your patients. If, for instance, you find yourself feeling slightly distressed, ask yourself, "What was just going through my mind?" You may uncover automatic thoughts such as:

> "This is too hard."
> "I may not be able to master this."
> "This doesn't feel comfortable to me."
> "What if I try it and it doesn't work?"

Experienced therapists whose primary orientation has not been cognitive may be aware of a different set of automatic thoughts:

> "This won't work."
> "The patient won't like it."
> "It's too superficial/structured/unempathetic/simple."

Having uncovered your thoughts, you can note them and refocus on your reading or turn to Chapters 8 and 9 which describe how to evaluate and respond to automatic thoughts. By turning the spotlight on your own thoughts, not only can you boost your cognitive therapy skills, but you can also take the opportunity to modify dysfunctional thoughts and influence your mood (and behavior), making you more receptive to learning.

A common analogy used for patients is also applicable to the beginning cognitive therapist. Learning the skills of cognitive therapy is similar to learning any other skill. Do you remember learning to drive or type or use a computer? At first, did you feel a little awkward? Did you have to pay a great deal of attention to small details and motions that now come smoothly and automatically to you? Did you ever feel discouraged? As you progressed, did the process make more and more sense and feel more and more comfortable? Did you finally master it to the point where you were able to perform the task with relative ease and confidence? Most people have had just such an experience learning a skill in which they are now proficient.

The process of learning is the same for the beginning cognitive therapist. As you will learn to do for your patients, keep your goals small, well defined, and realistic. Give yourself credit for small gains. Compare your progress to your level of ability before you started reading this book or to the time you first started learning about cognitive therapy. Be cognizant of opportunities to respond to negative thoughts in which you unfairly compare yourself to experienced cognitive therapists or in which you undermine your confidence by contrasting your current level of skill with your ultimate objectives.

Finally, the chapters of this book are designed to be read in the order presented. Readers might be eager to skip over introductory chapters in order to jump to the sections on techniques. You are urged, however, to attend carefully to the next chapter on conceptualization because a thorough understanding of a patient's cognitive makeup is necessary in order to choose techniques effectively. Chapters 3, 4, and 5 outline the structure of therapy sessions. Chapters 6 through 11 describe the basic building blocks of cognitive therapy: identifying and adaptively responding to automatic thoughts and beliefs. Additional cognitive and behav-

Core beliefs are the most fundamental level of belief; they are global, rigid, and overgeneralized. *Automatic thoughts*, the actual words or images that go through a person's mind, are situation specific and may be considered the most superficial level of cognition. The following section describes the class of *intermediate beliefs* that exists between the two.

ATTITUDES, RULES, AND ASSUMPTIONS

Core beliefs influence the development of an intermediate class of beliefs which consists of (often unarticulated) attitudes, rules, and assumptions. Reader E, for example, had the following intermediate beliefs:

Attitude: "It's terrible to be incompetent."
Rules/expectations: "I must work as hard as I can all the time."
Assumption: "If I work as hard as I can, I may be able to do some things that other people can do easily."

These beliefs influence his view of a situation, which in turn influences how he thinks, feels, and behaves. The relationship of these intermediate beliefs to core beliefs and automatic thoughts is depicted below:

Core beliefs
↓
Intermediate beliefs
(rules, attitudes, assumptions)
↓
Automatic thoughts

How do the core beliefs and intermediate beliefs arise? People try to make sense of their environment from their early developmental stages. They need to organize their experience in a coherent way in order to function adaptively (Rosen, 1988). Their interactions with the world and other people lead to certain understandings or learnings, their beliefs, which may vary in their accuracy and functionality. What is of particular significance to the cognitive therapist is that beliefs that are dysfunctional can be unlearned and new beliefs that are more reality based and functional can be developed and learned through therapy.

The usual course of treatment in cognitive therapy involves an initial emphasis on automatic thoughts, those cognitions closest to conscious awareness. The therapist teaches the patient to identify, evaluate, and modify her thoughts in order to produce symptom relief. Then the beliefs that underlie the dysfunctional thoughts and cut across many

situations become the focus of treatment. Relevant intermediate-level beliefs and core beliefs are evaluated in various ways and subsequently modified so that patients' conclusions about and perceptions of events change. This deeper modification of more fundamental beliefs makes patients less likely to relapse in the future (Evans et al., 1992; Hollon, DeRubeis, & Seligman, 1992).

RELATIONSHIP OF BEHAVIOR TO AUTOMATIC THOUGHTS

The cognitive model, as it has been explained to this point, can be illustrated as follows:

Core belief
↓
Intermediate belief
↓
Situation → Automatic thought → Emotion

In a specific situation, one's underlying beliefs influence one's perception, which is expressed by situation-specific automatic thoughts. These thoughts, in turn, influence one's emotions.

Proceeding one step further, automatic thoughts also influence behavior and often lead to a physiological response, as illustrated in Figure 2.1.

The reader who has the thoughts, "This is too hard. I'll never understand this," feels sad, experiences a sense of heaviness in his abdomen, and closes the book. Of course, had he been able to *evaluate* his thinking, his emotions, physiology, and behavior may have been positively affected. For example, he may have responded to his thoughts by saying, "Wait a minute. This may be hard, but it's not necessarily impossible. I've been able to understand this type of book before. If I keep at it, I'll probably understand it better." Had he responded in such a way, he may have reduced his sadness and kept reading.

To summarize, this reader felt sad because of his thoughts in a particular situation. Why did he have these thoughts when another reader did not? Unarticulated core beliefs about his incompetence influenced his perception of the situation.

As explained in the beginning of this chapter, it is essential for the therapist to learn to conceptualize patients' difficulties in cognitive terms in order to determine how to proceed in therapy—when to work on a specific goal, automatic thought, belief, or behavior; what techniques to choose; and how to improve the therapeutic relationship. The basic

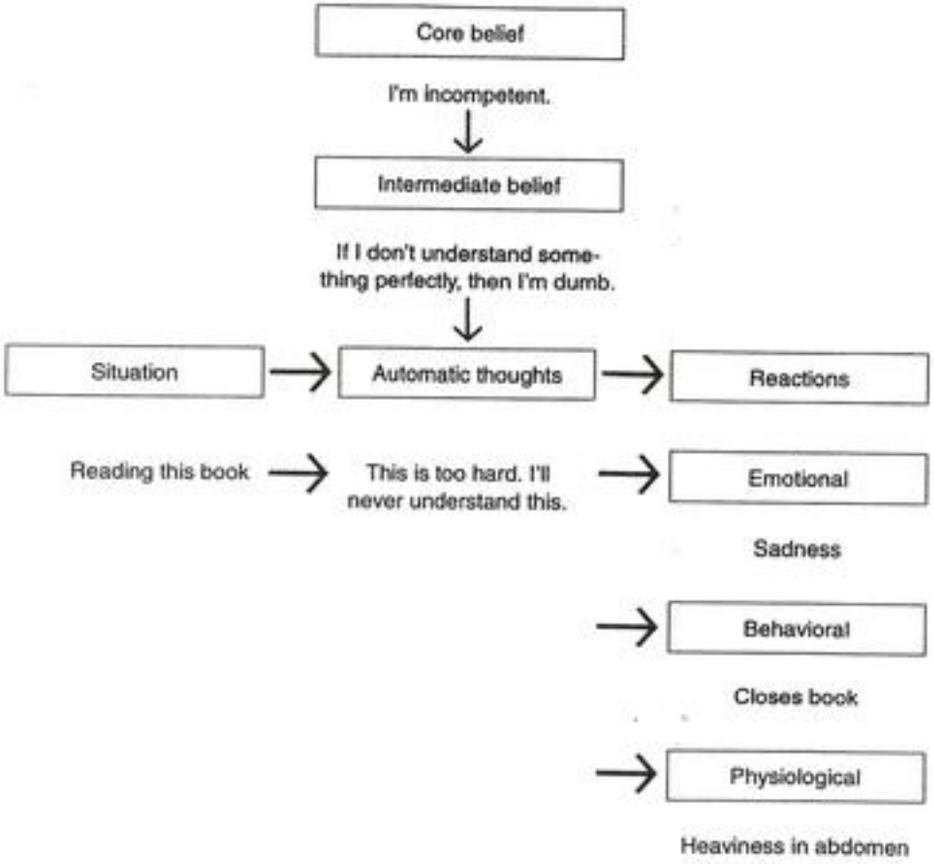


FIGURE 2.1. The cognitive model.

questions the therapist asks himself are: "How did this patient end up here? What vulnerabilities and life events (traumas, experiences, interactions) were significant? How has the patient coped with her vulnerability? What are her automatic thoughts, and what beliefs did they spring from?"

It is important for the therapist to put himself in his patient's shoes, to develop empathy for what the patient is undergoing, to understand how she is feeling, and to perceive the world through her eyes. Given her history and set of beliefs, her perceptions, thoughts, emotions, and behavior should make sense.

It is helpful for the therapist to view therapy as a journey and the conceptualization as the road map. The patient and he discuss the goals of therapy, the final destination. There are a number of ways

to reach that destination; for example, by main highways or back roads. Sometimes detours change the original plan. As the therapist becomes experienced and better at conceptualization, he fills in the relevant details in the road map and his efficiency and effectiveness improve. At the beginning, however, it is reasonable to assume that he may not accomplish therapy in the most effective way. A correct cognitive conceptualization aids him in determining what the main highways are and how best to travel.

Conceptualization begins at the first contact with a patient and is refined at every subsequent contact. The therapist hypothesizes about the patient, based on the data the patient presents. Hypotheses are either confirmed, disconfirmed, or modified as new data are presented. The conceptualization, therefore, is fluid. At strategic points, the therapist directly checks his hypotheses and formulation with the patient. Generally, if the conceptualization is on target, the patient confirms that it "feels right"—she agrees that the picture the therapist presents truly resonates with her.

CASE EXAMPLE

Sally is an 18-year-old college freshman who sought therapy for persistent sadness, anxiety, and loneliness. Her intake evaluator determined that she suffered from a major depressive episode of moderate severity which had begun during the first month of school, 4 months prior to her entry into therapy.

Most questions that the intake evaluator asked Sally were fairly standard, but several were added so the evaluator and therapist could begin to form a cognitive conceptualization. For example, the evaluator asked Sally when she generally felt the worst—which situations and/or times of day. Sally replied that she felt worst at bedtime, as she lay in bed, trying to fall asleep. The evaluator then asked the key question: *"What goes through your mind at these times? What specific thoughts and/or images do you have?"*

Thus, right from the beginning, a sample of important automatic thoughts is obtained. Sally replied that she has thoughts such as the following: "I'll never be able to finish my term paper." "I'll probably flunk out of here." "I'll never be able to make anything of myself." Sally also reported an image that flashed through her mind. She saw herself, suitcase in hand, trudging aimlessly down the street, looking quite downtrodden, directionless, and desperate. During the course of therapy, Sally's therapist rounds out his conceptualization. He organizes his thinking through the use of a Case Summary Worksheet (Appendix A) and a Case Conceptualization Diagram (see Chapter 10, Figure 10.2).

Sally's Core Beliefs

As a child, Sally tried to make sense of herself, others, and her world. She learned through her own experiences, through interactions with others, through direct observation, and through others' explicit and implicit messages to her. Sally had a highly achieving older brother. As a young child, she perceived that she could not do anything as well as her brother and started to believe, although she did not put it into words, that she was inadequate and inferior. She kept comparing her performance with her brother's and invariably came up lacking. She frequently had thoughts such as, "I can't draw as well." "He rides his bike better than me." "I'll never be as good a reader as he is."

Not all children with older siblings develop these kinds of dysfunctional beliefs. But Sally's ideas were reinforced by her mother, who frequently criticized her: "You did a terrible job straightening up your room. Can't you do anything right?" "Your brother got a good report card. But you? You'll never amount to anything." Sally, like most children, placed enormous stock in her mother's words, believing that her mother was correct about nearly everything. So when her mother criticized her, implying or directly stating that Sally was incompetent, Sally believed her completely.

At school, Sally also compared herself to her peers. While she was an above-average student, she compared herself only to the best students, again coming up short. She had thoughts such as, "I'm not as good as they are." "I'll never be able to understand this stuff as well as they can." So the idea that she was inadequate and inferior kept being reinforced. She often screened out or discounted positive information that contradicted these ideas. When she got a high mark on a test, she would tell herself, "The test was easy." When she learned ballet and became one of the best dancers in the group, she thought, "I'll never be as good as my teacher." She usually made negative interpretations, which confirmed her dysfunctional beliefs. For example, when her mother yelled at her for bringing home an average report card, she thought, "Mom's right. I am stupid." She consistently interpreted negative events as demonstrating her shortcomings. In addition, when positive events such as winning an award occurred, she often discounted them: "I was just lucky. It was a fluke."

This process led to Sally's consolidating a negative core belief about herself. Sally's negative beliefs were not rock solid, however. Her father, though not around as much as Sally's mother, was generally encouraging and supportive. When he taught her to hit a baseball, for example, he would praise her efforts. "That's good . . . good swing . . . you're getting it . . . keep going." Some of Sally's teachers, too, praised her performance in school. Sally also had positive experiences with friends. She saw that if she tried hard, she could do some things better than her friends—baseball, for example. So Sally also developed a counterbalancing positive belief that she was competent in some respects.

Sally's other core beliefs about her world and about other people were, for the most part, positive and functional. She generally believed that other people were friendly, trustworthy, and accepting. And she perceived her world as being relatively safe, stable, and predictable.

Again, Sally's core beliefs about herself, others, and her world were her most basic beliefs, which she had never really articulated until she entered therapy. As a young adult, her more positive core beliefs were dominant until she became depressed, and then her highly negative core beliefs became activated.

Sally's Attitudes, Rules, and Assumptions

Somewhat more amenable to modification than her core beliefs were Sally's intermediate beliefs. These attitudes, rules, and assumptions developed in the same way as core beliefs, as Sally tried to make sense of her world, of others, and of herself. Mostly through interactions with her family and significant others, she developed the following attitudes and rules:

"I should be great at everything I try."
"I should always do my best."
"It's terrible to waste your potential."

As was the case with her core beliefs, Sally had not fully articulated these intermediate beliefs. But the beliefs nevertheless influenced her thinking and guided her behavior. In high school, for example, she did not try out for the school newspaper (though it interested her) because she assumed she could not write well enough. She felt both anxious before exams, thinking that she might not do well, and guilty, thinking that she should have studied more.

When her more positive core beliefs predominated, however, she saw herself in a more positive light, although she never completely believed that she was competent and not inferior. She developed the assumption: "If I work hard, I can overcome my shortcomings and do well in school." When she became depressed, however, Sally did not really believe this assumption any longer and substituted the belief, "Because of my deficiencies, I'll never amount to anything."

Sally's Strategies

The idea of being inadequate had always been quite painful to Sally, and she developed certain behavioral strategies to shield herself from this

pain. As might be gleaned from her intermediate beliefs, Sally worked hard at school and at sports. She overprepared her assignments and studied quite hard for tests. She also became hypervigilant for signs of inadequacy and redoubled her efforts if she failed to master something at school. She rarely asked others for help for fear they would recognize her inadequacy.

Sally's Automatic Thoughts

While Sally did not articulate these core beliefs and intermediate beliefs (until therapy), she was at least somewhat aware of her automatic thoughts in specific situations. In high school, for example (during which time she was not depressed), she tried out for the girls' softball and hockey teams. She made the softball team and thought, "That's great. I'll get Dad to practice batting with me." When she failed to make the hockey team, she was disappointed but not particularly self-critical.

In college, however, Sally became depressed during her freshman year. Later, when she considered playing an informal baseball game with students in her dorm, her depression influenced her thinking: "I'm no good. I probably won't even be able to hit the ball." Similarly, when she got a "C" on an English literature examination, she thought, "I'm so stupid. I'll probably fail the course. I'll never be able to make it through college."

To summarize, in her nondepressed high school years, Sally's more positive core beliefs were activated and she generally had relatively more positive (and more realistic) thoughts. In her freshman year in college, however, her negative beliefs predominated during her depression, which led her to interpret situations quite negatively and to have predominantly negative (and unrealistic) thoughts. These distorted thoughts also led her to *behave* in self-defeating ways, thereby giving her more ammunition with which to put herself down.

Sequence Leading to Sally's Depression

How is it that Sally became depressed? Certainly, her negative beliefs helped predispose her to depression. When she got to college, she had several experiences which she interpreted in a highly negative fashion. One such experience occurred the first week. She had a conversation with other freshmen in her dorm who were relating the number of advanced placement courses and exams they had taken which exempted them from several basic freshman courses. Sally, who had no advanced placement credits, began to think how superior these students were to her. In her economics class, her professor outlined the course requirements and Sally immediately thought, "I won't be able to do the research paper." She had difficulty understanding the first chapter in her statistics

book and she thought, "If I can't even understand Chapter 1, how will I ever make it through the course?"

So Sally's beliefs made her vulnerable to interpreting events in a negative way. She did not question her thoughts but rather accepted them uncritically. The thoughts and beliefs themselves did not cause the depression. However, once the depression set in, these negative cognitions strongly influenced her mood. Her depression undoubtedly was *caused* by a variety of biological and psychological factors.

For example, as the weeks went on, Sally began to have more and more negative thoughts about herself and began to feel more and more discouraged and sad. She began to spend an inordinate amount of time studying, although she did not accomplish a great deal because of decreased concentration. She continued to be highly self-critical and even had negative thoughts about her depressive symptoms: "What's wrong with me? I shouldn't feel this way. Why am I so down? I'm just hopeless." She withdrew somewhat from new friends at school and stopped calling her old friends for support. She discontinued running and swimming and other activities that had previously provided her with a sense of accomplishment. Thus, she experienced a paucity of positive inputs. Eventually, her appetite decreased, her sleep became disturbed, and she became enervated and listless. Sally may indeed have had a genetic predisposition for depression; however, her perception of and behavior in the circumstances at the time undoubtedly facilitated the expression of a biological and psychological vulnerability to depression.

SUMMARY

Conceptualizing a patient in cognitive terms is crucial in order to determine the most efficient and effective course of treatment. It also aids in developing empathy, an ingredient that is critical in establishing a good working relationship with the patient. In general, the questions to ask when conceptualizing a patient are:

How is it that the patient came to develop this disorder?
What were significant life events, experiences, and interactions?
What are her most basic beliefs about herself, her world, and others?
What are her assumptions, expectations, rules, and attitudes (intermediate beliefs)?
What strategies has the patient used throughout life to cope with these negative beliefs?
Which automatic thoughts, images, and behaviors help to maintain the disorder?

How did her developing beliefs interact with life situations to make the patient vulnerable to the disorder?
What is happening in the patient's life right now and how is the patient perceiving it?

Again, conceptualization begins at the first contact and is an ongoing process, always subject to modification as new data are uncovered and previous hypotheses are confirmed or rejected. The therapist bases his hypotheses on the data he has collected, using the most parsimonious explanation and refraining from interpretations and inferences not clearly based on actual data. The therapist checks out the conceptualization with the patient at strategic points to ensure that it is accurate as well as to help the patient understand herself and her difficulties. The ongoing process of conceptualization is emphasized throughout this book; Chapters 10 and 11 illustrate further how historical events shape a patient's understanding of herself and her world.

Chapter 3

STRUCTURE OF THE FIRST THERAPY SESSION

A major goal of the cognitive therapist is to make the process of therapy understandable to both therapist and patient. The therapist also seeks to do therapy as efficiently as possible. Adhering to a standard format (as well as teaching the tools of therapy to the patient) facilitates these objectives.

Most patients feel more comfortable when they know what to expect from therapy, when they clearly understand their responsibilities and the responsibilities of their therapist, and when they have a clear expectation of how therapy will proceed, both within a single session and across sessions over the course of treatment. The therapist maximizes the patient's understanding by explaining the structure of sessions and then adhering to that structure.

Experienced therapists who are unaccustomed to setting agendas and structuring sessions as described in this chapter often feel uncomfortable with this fundamental feature of cognitive therapy. Such discomfort is usually associated with negative predictions: The patient will not like it; the patient will feel controlled; it will make me miss important material; it is too rigid. Therapists are urged to test these ideas directly through implementing the structure as specified and noting the results. Therapists who initially feel awkward with a more tightly structured session often find that the process gradually becomes second nature, especially when they note the accompanying results.

The basic elements of a cognitive therapy session are a brief update (including rating of mood and a check on medication compliance, if applicable), a bridge from the previous session, setting the agenda, a review of homework, discussion of issue(s), setting new homework, and summary and feedback. Experienced cognitive therapists may deviate

f their lives. Negative core beliefs of personality disorder patients lly much more difficult to modify (Beck et al., 1990; Young, 1990) they typically have fewer positive core beliefs and they have ed a multitude of negative core beliefs that interconnect, sup- each other like a network.

dentifying and modifying core beliefs, the therapist does the g during the course of therapy (each step is described later in ɔter):

Mentally hypothesizes from which category of core belief ɛssness" or "unlovability") specific automatic thoughts appear arisen.

Specifies the core belief (to himself) using the same techniques to identify the patient's intermediate beliefs.

Presents his hypothesis about the core belief(s) to the patient, for confirmation or disconfirmation; refines his hypothesis he core belief as the patient provides additional data about and childhood situations and her reactions to them.

Educates the patient about core beliefs in general and about cific core belief; guides the patient in monitoring the operation ore belief in the present.

Begins to evaluate and modify the core belief with the patient; he patient in specifying a new, more adaptive core belief; es the childhood origin of the core belief, its maintenance ı the years, and its contribution to the patient's present diffi- continues to monitor the activation of the core belief in the ; uses "rational" methods to decrease the strength of the old lief and to increase the strength of the new core belief; and periential or "emotional" techniques with heightened affect ıe patient no longer strongly believes a core belief "rationally" llectually" but still believes it "emotionally."

CATEGORIZING CORE BELIEFS

ɔned previously, patients' core beliefs may be categorized in the ess realm, the unlovability realm, or both. Whenever the patient data (problems, automatic thoughts, emotions, behavior, his- therapist "listens" for the category of core belief that seems to ı activated. For example, when Sally expresses thoughts about being too hard, about her inability to concentrate, and about of failing, her therapist hypothesizes that a core belief in the ategory was operating. (Another patient consistently expresses of others not caring about her and fears that she is too different

from others to sustain a future relationship. This patient has a core belief in the category of unlovability.)

The top of Figure 11.1 lists typical core beliefs in the helpless category. Themes include being personally helpless (powerless, vulnerable, trapped, out of control, weak, needy) and not measuring up in terms of achievement (failure, inferior, not good enough, loser, disrespected).

The bottom of Figure 11.1 lists typical core beliefs in the unlovable category. Themes include being unworthy, undesirable, and not measuring up (not in achievement but rather in being defective in some way so as to preclude gaining the sustained love and caring of others).

Sometimes it is clear in which category a given core belief belongs, especially when the patient actually uses words such as "I am helpless," or "I am unlovable." At other times, the therapist may not know initially which category of core belief has been activated. For example, a depressed patient says, "I'm not good enough." The therapist then needs

Helpless core beliefs	
I am helpless.	I am inadequate.
I am powerless.	I am ineffective.
I am out of control.	I am incompetent.
I am weak.	I am a failure.
I am vulnerable.	I am disrespected.
I am needy.	I am defective (i.e., I do not measure up to others).
I am trapped.	I am not good enough (in terms of achievement).
Unlovable core beliefs	
I am unlovable.	I am unworthy.
I am unlikable.	I am different.
I am undesirable.	I am defective (i.e., so others will not love me).
I am unattractive.	I am not good enough (to be loved by others).
I am unwanted.	I am bound to be rejected.
I am uncared for.	I am bound to be abandoned.
I am bad.	I am bound to be alone.

FIGURE 11.1. Categories of core beliefs. Copyright 1995 by Judith S. Beck, Ph.D.

Cognitive Distortions

1. **All-or-nothing thinking:** Viewing situations on one extreme or another instead of on a continuum.
   Ex. "If my child does bad things, it's because I am a bad parent."

2. **Catastrophizing:** Predicting only negative outcomes for the future.
   Ex. "If I fail my final, my life will be over."

3. **Disqualifying or discounting the positive:** Telling yourself that the good things that happen to you don't count.
   Ex. "My daughter told her friend that I was the best Dad in the world, but I'm sure she was just being nice."

4. **Emotional reasoning:** Letting one's feeling about something overrule facts to the contrary.
   Ex. "Even though Steve is here at work late every day, I know I work harder than anyone else at my job."

5. **Labeling:** Giving someone or something a label without finding out more about it/them.
   Ex. "My daughter would never do anything I disapproved of."

6. **Magnification/minimization:** Emphasizing the negative or playing down the positive of a situation.
   Ex. "My professor said he made some corrections on my paper, so I know I'll probably fail the class."

7. **Mental filter/tunnel vision:** Placing all one's attention o, or seeing only, the negatives of a situation.
   Ex. "My husband says he wishes I was better at housekeeping, so I must be a lousy wife."

8. **Mind reading:** Believing you know what others are thinking.
   Ex. "My house was dirty when my friends came over, so I know they think I'm a slob."
   Ex. "My daughter's boyfriend got suspended from school. He's a loser and won't ever amount to anything."

9. **Overgeneralization:** Making an overall negative conclusion beyond the current situation.
   Ex. "My husband didn't kiss me when he came home this evening. Maybe he doesn't love me anymore."

10. **Personalization:** Thinking the negative behavior of others has something to do with you.
    Ex. "My daughter has been pretty quiet today. I wonder what I did to upset her."

11. **"Should" and "must" statements:** Having a concrete idea of how people should behave.
    Ex "I should get all A's to be a good student."